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APPENDIX TO THE PERFORMANCE PLAN

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

FINAL FY 2001 ANNUAL PERFORMANCE PLAN, REVISED FINAL FY 2000 GPRA ANNUAL PERFORMANCE PLAN AND FY 1999 PERFORMANCE REPORT

INTRODUCTION

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the lead Federal agency for improving the quality and availability of treatment and prevention services for substance abuse and mental illness. Long term measures of success in achieving the agency's statutory mission are the reduction in national rates of substance abuse, and reduction in rates of untreated mental illness. This SAMHSA Final 2001 Annual Performance Plan, Revised Final FY 2000 GPRA Annual Performance Plan and FY 1999 Performance Report includes data regarding the success of SAMHSA's strategies and programs.

SAMHSA has thoroughly assessed and continues to strengthen its performance measurement, quality improvement and accountability systems. For example, the agency has dramatically expanded the National Household Survey on Drug Abuse (NHSDA) so that, for the first time, national and State-level data will be available annually on critical indicators of substance abuse such as prevalence, use patterns, age at first use, risk factors, treatment and disability. An array of NHSDA data is reported to chart progress by age, gender, ethnicity, and rural/urban service setting and within States as well as at the national level. The first data from the expanded survey will be available in August of FY 2000.

Another feature in SAMHSA's progress in capturing information more systematically about the impact of its programs, is the development and implementation of a core client outcomes data set for the Block Grants and for SAMHSA's discretionary programs. The core data set for the block grants was developed in partnership with the States and has been approved by OMB for voluntary collection of data. States are currently pilot testing these and other measures to be used in reporting on SAMHSA's Community Mental Health Services (CMHS) and Substance Abuse Prevention and Treatment (SAPT) block grants. In a related effort, SAMHSA received OMB approval to require recipients of SAMHSA Knowledge Development and Application (KDA) grants and Targeted Capacity Expansion (TCE) grants to report on a similar core data set. As a result of these efforts, all of SAMHSA's programs that involve client interventions will report on a common set of client outcome indicators.

SAMHSA continues to organize its activities around four long term SAMHSA goals, which have been revised slightly for FY 2001. These goals facilitate performance measurement reporting and

development by organizing programs by a common purpose. In addition, the goals help SAMHSA achieve an appropriate balance of resources and activities across its programs in accomplishing its mission.

SAMHSA's GPRA Performance Plan and Performance Report contain two parts. Part I presents an overview of the agency, its mission, goals, structure, and core performance measures and highlights key efforts with partners outside the agency. Progress in meeting the agency's GPRA goals for FY 1999 is summarized. Part II provides SAMHSA's program-specific performance goals and measures, and progress towards meeting them, grouped by general target area: substance abuse treatment, substance abuse prevention, and mental health treatment and prevention. In addition, SAMHSA integrates its budget narrative and GPRA plan within the HHS format for GPRA, so that outcomes and performance indicators for FY 2001 proposed initiatives can be found in the FY 2001 budget narrative.

PART I - AGENCY CONTEXT FOR PERFORMANCE MEASUREMENT

1.1 Agency Mission and Long-Term Goals

Mission

SAMHSA's statutory mission is to improve the quality and availability of services for substance abuse and mental illness. This mission was established in statute in 1992 in section 501 of the Public Health Services Act. SAMHSA is organized into three operational Centers: the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Center for Mental Health Services (CMHS). In addition, there are several offices with cross-cutting responsibilities, such as the Office of Applied Studies and the Office of Managed Care. To accomplish the agency's mission, the combined and coordinated efforts of Federal, State, and local governments, business, and private citizens are needed. SAMHSA's mission is reflected in the Performance Measures of Effectiveness (PME) of the Office of National Drug Control Policy (ONDCP), the DHHS Strategic Plan, and Healthy People 2000 and Healthy People 2010 goals as described in Appendix A.3. SAMHSA's four GPRA goals reflect the agency's overall strategy, and emphasize the contribution that the agency can make through the outcomes of its programs.

Mission Level Outcomes

SAMHSA has identified six outcome measures to track success of the nation as a whole in improving access to effective substance abuse and mental health services. Four of the measures are for substance abuse and are part of the Office of National Drug Control Policy (ONDCP) Performance Measures of Effectiveness (PME). Several of the measures also are included in the January 2000 release of Healthy People 2010. Data sources are under development for the remaining measures.

Substance Abuse Treatment:

1. Reduce the size of the treatment gap, defined as the difference between those seeking substance abuse treatment and those receiving it. By 2002, reduce the public treatment gap by at least 20 percent as compared to the 1996 base year; by 2007 reduce the gap by at least 50%. Source: ONDCP PME Goal 3, Objective 1, Target 1. See also Healthy People 2010, Chapter 26, Developmental Objectives 18 and 20. Data sources exist, but precise methodology is under development.

2. Achieve for those completing substance abuse treatment programs (a) 10 percent increase in full time employment (adults); (b) a 10 percent increase in educational status (adolescents); (c) a 10 percent decrease in illegal activity; and (d) a 10 percent increase in general medical health by 2007, as compared to the 2001 base year. Source: ONDCP PME Goal 3, Objective 1, Target 2. Data source SAMHSA NTOMS (under development; see FY2001 budget proposal). Not currently included in Healthy People 2010 pending development of data source.

Substance Abuse Prevention:

1. Increase to 80% youth perception of risk; increase to 95% youth disapproval of use; reduce youth use in the past 30 days by 50%; increase age of first use by 36 months by FY 2007. Source: ONDCP PME Goal 1, Objective 2, Targets 1, 2; Goal 1 Impact Targets (a), (b). See also Healthy People 2010, Chapter 26, Objectives 17, 16, 10,9a. Data Source SAMHSA National Household Survey on Drug Abuse; NIH/NIDA Monitoring the Future.

2. Reverse the upward trend and cut marijuana use among 12 to17 year-olds by 25 percent from the 1995 baseline of 8.2 percent to 6.2 percent by the end of FY 2002. Reduce the prevalence of past month use of other illegal drugs and alcohol by youth by 20 percent by 2002 as measured against the 1996 base year. Reduce this prevalence by 50% by 2007. Reduce tobacco use by youth by 25% by 2002 and by 55% by 2007. Source: ONDCP PME Goal 1, Goal Impact Target (a). See also Healthy People 2010 Chapter 26, Objective 10. Data Source SAMHSA National Household Survey on Drug Abuse.

Mental Health Treatment and Prevention:

1. Reduce rates of untreated mental illness.

2. Improve outcomes for individuals with mental illness.

National data sources for these indicators do not exist at this time. A FY 2000 mental health supplement to the National Household Survey on Drug Abuse has been proposed, which includes an

adolescent mental health module and questions related to mental health service utilization for adolescents and adults. Upon approval and availability of data in FY 2000 and FY 2001, SAMHSA will formulate specific mental health indicators for this section of the GPRA performance plan, and propose expansion or revisions to Chapter 23 of Healthy People 2010 as appropriate. See Healthy People 2010 Chapter 23, Objectives 1-9, which currently support aspects of these two indicators. Note that the remaining Healthy People objectives also target issues and processes which support the availability of treatment and the improvement of outcomes.

For further detail regarding links with the HHS Strategic Plan and the National Drug Control Strategy See Appendix A3.. See the budget narrative for links to FY 2001 Secretarial Initiatives. Specifically, SAMHSA is co-lead for the Mental Health Initiative, and is a participant in the Health Promotion and Disease Prevention Initiative and the Integrated Surveillance Initiative. Note that several of the CSAP programs contained in Part II of this Performance Plan support the 1997 Youth Substance Abuse Prevention Initiative.

Long-Term SAMHSA Goals

Four Long-Term goals form SAMHSA's comprehensive strategy and focused commitment to address the nation's substance abuse and mental health problems. SAMHSA's budget lines track each of the long term goals and are included below to illustrate the integrated design of our performance measurement system. The objectives for these measures are developmental. SAMHSA is continuing to develop and implement measures and data systems needed to track progress on each of these four goals:

Goal 1: Assure Services Availability

Goal 2. Meet Unmet and Emerging Needs

Goal 3. Bridge the Gap Between Knowledge and Practice

Goal 4. Strengthen Data Collection to Improve Quality and Enhance Accountability

Goal 1: Assure services availability
Objectives: a) Increase utilization. b) Promote systems improvement.

Relevant budget lines: Substance Abuse Prevention and Treatment (SAPT) Block Grant; Community Mental Health Services (CMHS) Block Grant; Protection and Advocacy for Individuals with Mental

Illnesses (PAMI) formula grant; Projects for Assistance in Transition from Homelessness (PATH) formula grant.

The majority of SAMHSA's resources (77% in FY 1999) supports Goal 1, through SAMHSA's block and formula grants. These programs provide critical support to States' efforts to plan and implement effective mental health and substance abuse treatment and prevention services. A defining characteristic of these programs is that the recipient, not the Federal Government, determines how funds will be used within the parameters of each program. SAMHSA works with States, territories and other recipients designated by statute to create comprehensive service systems, improve the quality of services, and monitor unmet needs and service effects to make a positive impact at the local level. The CMHS and SAPT block grants support State and regional planning, and provide resources to support comprehensive substance abuse and mental health treatment and prevention services. A key feature of the SAPT and CMHS Block Grants is a 5% set-aside that is used by SAMHSA, as provided by legislation, for data collection, technical assistance, and evaluation.

SAMHSA has recently secured OMB approval for the collection of State data on a core set of performance measures as part of the block grant applications for both block grants. Under the terms of the approval, states are now reporting the data on a voluntary basis beginning in FY 1999 for the CMHS Block Grant and in FY 2000 for the SAPT Block Grant. Pilot projects are under way to test the utility of a broader array of performance measures for the CMHS and SAPT block grants. Performance measurement has advanced significantly in SAMHSA's two other mental health formula grants, PATH and PAIMI. PATH grants support State services for persons who are mentally ill and homeless. PAIMI resources protect persons with mental illnesses from abuse, neglect, and civil rights violations while under treatment in residential treatment facilities. Performance measures and targets have been established for the PATH and PAIMI formula grants.

Goal 2. Meet unmet and emerging needs
Objectives: a) Implement proven strategies and interventions b) Increase utilization

Relevant Budget Lines: Targeted Capacity Expansion; Children's Mental Health Services

SAMHSA's Targeted Capacity Expansion (TCE) programs are designed as focused, quick response projects to help community based providers, tribal and local governments, States and territories. TCE focuses the resources necessary to address treatment and prevention needs that are unique to a particular population or geographic area, or to stem emerging problems before they become endemic. In addition, SAMHSA also works with States and Tribal governments to leverage government and private resources to address local needs and to monitor the impact of these targeted efforts.

Targeted Capacity Expansion (TCE) programs are designed to assist community based providers, Tribal governments, local governments and states and territories to respond to unique local problems or to emerging or crisis developments. For example, as methamphetamine use has spread over the last three years from the Northwest and Texas to the Midwest and South, local substance abuse treatment services have been hard pressed to meet the new demands while servicing the already significant demands for treatment of other drug addiction. TCE is a highly responsive means for quickly targeting resources and expertise on emerging and unique problems identified by States and local governments. In addition, every TCE program includes a significant evaluation and accountability component. Most require that recipients report on the SAMHSA core performance measures as well as measures specific to the targeted program.

Goal 3. Bridge the gap between knowledge and practice
Objectives: a) Generate new evidence based information b) Facilitate adoption of evidence based strategies

Relevant Budget Lines: Knowledge Development and Application (KDA); High Risk Youth

SAMHSA's Knowledge Development and Application (KDA) programs have two dimensions. These programs improve the effectiveness of the nation's substance abuse and mental health services by developing models for organizing, financing, and delivering prevention and treatment services. Many programs verify innovations that have been developed in research settings by subjecting them to field testing in community service systems. As new techniques are tested and demonstrated to be effective, SAMHSA's Knowledge Application programs channel them to training and dissemination systems designed to facilitate broader scale adoption. Each KDA program uses unique performance measures to assess effectiveness, and, where relevant, SAMHSA's client outcome measures.

Topics for KDA programs are generated through a collaborative process with State officials, practitioners, consumers, and families so that research and development efforts focus on the most difficult problems facing the mental health and substance abuse fields. For example, SAMHSA's KDA programs have developed and tested on challenges such as outreach and treatment of homeless persons with co-occurring mental illness and substance abuse, models for preventing violence in schools and workplace substance abuse prevention programming. As SAMHSA-funded KDA models are demonstrated to be effective, SAMHSA initiates programs to bridge the gap between scientifically proven knowledge and actual practice.

Goal 4. Strengthen data collection to improve quality and enhance accountability
Objectives: a) Ensure that data are available for the most critical areas of need. b) Ensure that data are timely and useful.

Relevant Budget Lines: National data collection

SAMHSA's data collection activities track national and State-level trends in substance abuse and mental health issues and services. Data are used to detect emerging problems, and assess program and policy effects. SAMHSA collects national data through efforts such as the National Household Survey on Drug Abuse (NHSDA). These data are used to measure the impact of national substance abuse and mental health policies, such as the Office of National Drug Control Policy's Performance Measures of Effectiveness (Goals 1 and 3), and Healthy People 2010 (chapters 23 and 26).

Data collection and reporting are fundamental for measuring progress toward meeting SAMHSA's mission and assuring accountability for the effective use of resources entrusted to the agency. Data systematically collected and analyzed at national, State, and program levels are the essential building blocks needed to guide SAMHSA's policies and programs. Progress made in expanding the NHSDA, in creating the Core Client Outcome measures for the Block, TCE and KDA grants programs, and in developing empirical targets for each one of SAMHSA's programs make it possible for SAMHSA to report substantial progress in this GPRA report, and to anticipate even greater strides toward empirically-based accountability in future GPRA reports.

1.2 Organization, Programs, Strategies, Operations, and Resources

Organization

SAMHSA carries out its mission and Long-Term goals through three Centers: the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Center for Mental Health Services (CMHS). Offices at the agency level with cross-cutting responsibilities within the Office of the Administrator include the Office of Applied Studies, the Office of Policy and Program Coordination, and the Office of Managed Care.

Program Structure-Strategy

The agency's four Long-Term goals previously discussed are the framework that continues to guide SAMHSA's evolving program structure. The graph below illustrates our goal structure. Each SAMHSA program fits under one of these goals. SAMHSA's program strategy ensures that if programs contribute to one of the four goals and report results according to the measures identified for that goal, they will improve the quality and availability of services.
This model is represented below:

Operations and Resources

SAMHSA's responsibilities extend to a broad array of issues relating to substance abuse and mental illness, ranging from a major school violence prevention program to new initiatives to prevent and treat substance abuse and HIV/AIDS in African-American, Tribal governments and other minority communities, to supporting the Office of Personnel Management's requirement that all health plans in the Federal Employees Health Benefit Program cover mental health and substance abuse services at full parity with other health conditions. To plan and execute this broad range of responsibilities, SAMHSA employs a wide range of professional personnel, with expertise in mental health and substance abuse services, epidemiology and statistics, policy and finance. As the agency's responsibilities and budget have expanded, program management resources have not kept pace with program operations. The agency has reorganized numerous functions and programs to streamline operations and conserve program resources. Investments in information technologies and team training enhance and extend the reach of SAMHSA's professional resources.

1.3 Partnerships and Coordination

Mental health and substance abuse issues involve a broad array of partners and stakeholders whose input is critical to the determination of agency priorities. SAMHSA has a key role in bringing together partners and stakeholders, helping to ensure that efforts are complementary, and ensuring that SAMHSA's priorities are based firmly in the needs of the field. SAMHSA's established networks with its grantees and external partners contribute significantly to the effectiveness of the Agency.

Partners and stakeholders include:

- State and local governments through programs such as the Comprehensive Community Mental Health Services for Children and Their Families, Targeted Capacity Expansion and Block Grants.

- Non-profit treatment providers such as community mental health clinics, substance abuse clinics and other community organizations.

- Consumers/clients of substance abuse and mental health services including their family members.

- A wide range of different grantees such as hospitals, universities, community agencies and research institutes.

- Foundations such as the Robert Wood Johnson Foundation, the Casey Family Foundation and the Kaiser Family Foundation.

- A variety of volunteer and other organizations that do not fall within the categories mentioned.

Some SAMHSA programs have performance goals, measures, and targets that were developed with partners. Examples include the block grants, the Protection and Advocacy Program for Persons with Mental Illness, State Incentive Grants and the Starting Early, Starting Smart Program for at-risk families and children. In addition, SAMHSA's mission and Long-Term goals provide data support for ONDCP's Performance Measures of Effectiveness (PME) Goals 1 and 3. SAMHSA participates with other Federal agencies in these efforts, and will track selected indicators in this section of its GPRA plan in order to show trends that reflect the outcomes of the combined efforts of SAMHSA and all of its partners.

Involved Federal agencies include all of the HHS components, especially the Health Care Financing Administration, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute of Mental Health; and other federal agencies such as the Office

of National Drug Control Policy; the Department of Education; the Department of Veterans Affairs; the Department of Justice; the Department of Transportation; the Department of Housing and Urban Development; and the Department of Defense.

1.4 Summary FY 1999 Performance Report: Accountability through Performance Measurement

Performance Commitment

SAMHSA's intensive performance measurement development efforts this year have focused upon completing the core sets of client outcome indicators for SAMHSA-funded programs that involve client interventions. This effort has resulted in a set for SAMHSA's discretionary programs and a similar set for each Block Grant. The indicators consist of a small number of variables that have emerged from several national consensus development processes as extremely important for charting the effectiveness of substance abuse and mental health prevention and treatment services. Work in testing and implementing these indicators continues.

Core Client Outcomes for Discretionary Programs

SAMHSA and the Centers have developed a core set of client outcome measures for discretionary programs and projects which will be applied, as appropriate, to programs funded in FY 1999 and beyond. A request for approval to collect data using these core client outcome measures has recently received OMB approval. The client outcome measures for discretionary programs will be utilized and reported by Knowledge Development and Targeted Capacity Expansion programs, where appropriate. The data will contribute to reporting of agency progress toward improving client outcomes through its discretionary programs.

The core client outcomes tool for data collection draws upon several widely used data collection instruments (e.g., the Addiction Severity Index, the National Household survey on Drug Abuse, the McKinney Homeless Program reporting system, Monitoring the Future, Student Survey of Risk and Protective Factors, and Prevalence of Alcohol, Tobacco, and Other Drug Use). Appendix B.3 lists the measures, including their source and the rationale for their selection.

Block Grants

SAMHSA has worked with the States over a period of years to develop a core set of outcome indicators applicable to the block grants. SAMHSA received approval in 1998 to collect mental health information as part of the FY 1999 Community Mental Health Services block grant application, and has just received approval in August 1999 to collect voluntary substance abuse prevention and treatment information as part of the FY 2000 Substance Abuse Prevention and Treatment block grant

application. The indicators are listed in the sections of this plan pertaining to the Block Grants, which are Sections 2.1, 2.8, and 2.19.

Summary of Performance Success

SAMHSA has made impressive strides in FY 1999 to improve performance measures for all of its programs. Targets were established for all of the 30 distinct SAMHSA programs by FY 1999. FY 1999 targets have been met or exceeded on 87% of the GPRA measures for which FY 1999 data are available. Some data are not obtainable in time for this submission. Those data will be reported in the FY 2002 submission, as indicated in the tables in Part II. The performance table below summarizes SAMHSA GPRA performance for FY 1999.

1999 Performance Report Summary

	99 targets	Exceeded/ Met/Unmet	Yet to be Reported
CSAT	8	2/1/2	3
CSAP	13	8/4/1	0
CMHS	20	7/1/1	11
OMC	2	0/1/0	1
OAS	2	0/2/0	0
Totals	45	17/9/4	15

Performance Highlights

Mental Health Services

< The Comprehensive Community Mental Health Services for Children and Their Families Program in 1999 served an estimated 15,600 children in increasing access to treatment and quality mental health services through community rather than in residential placements.

< The Projects for Assistance in Transition for Homeless (PATH) program has been successful in reaching seriously impaired homeless persons, for whom at least 59% had co-occurring serious

mental illnesses and substance abuse disorders, more than half of were living in the streets, in shelters or in temporary housing and had been homeless for more than 30 days.

Substance Abuse Prevention

< In the Community Partnership Program data showed that 24 representative partnership communities had lower rates of substance abuse in comparison to the control group communities.

< Program Surveys also revealed fewer reports of adult illicit drug use in Community Partnership Programs.

Substance Abuse Treatment

< Technical assistance events resulted in 66% of States making systems, program or practice improvements. This is 16% above the 1999 target.

< Preliminary pilot studies in CSAT's Marijuana Treatment for Youth program, have demonstrated actual reduction in marijuana use with five interventions. In untreated adolescents, marijuana use typically accelerates until age 20, with out-patient treatment only reducing or leveling the slope of increasing use.

Plans Included in the Submission

SAMHSA submitted a combined FY 2000 and Revised Final FY 1999 GPRA performance plan as part of its FY 2000 Congressional Justification. Accordingly, that plan is the basis for the FY 1999 performance report. The FY 2001 Performance Plan builds on the four basic program goals for the agency framework of the FY 2000 plan.

Summary of Performance Challenges

SAMHSA has made considerable progress during the past year toward obtaining needed data and assuring that there is the necessary emphasis on evaluation of agency programs. However, several

major challenges remain as the agency seeks to collect and analyze performance data for national policy goals as well as to obtain data for assessing the performance of certain of SAMHSA's programs.

Support of State Data Efforts

Examples of SAMHSA support of State data collection efforts include needs assessment activities in CSAT and CSAP, and efforts to support States in developing performance measures and identifying and collecting related outcome and other data. In order to make full use of the Block Grants as a mechanism for improving services and other activities in States, good information must exist on the activities and services needs of the State and on the outcomes of State efforts. SAMHSA is continuing to use available Block Grant set-aside funds to support activities to help States develop an adequate data infrastructure to permit the collection and reporting of essential data.

National Data Collection

Examples of SAMHSA national surveys include the National Household Survey on Drug Abuse (NHSDA), and the Inventory of Mental Health Organizations. Data from these surveys are used for GPRA purposes to set context and to establish and/or track the agency's broad, Long-Term goals that are also part of Healthy People 2010 and the ONDCP Performance Measures of Effectiveness effort. SAMHSA's top national data collection priority is the expansion of the NHSDA to permit State-level estimates. This expansion will assist SAMHSA in providing enhanced technical assistance to States which need additional assistance, as reflected by higher risk factors and prevalence of substance abuse. A second priority is the development of the National Treatment Outcomes Monitoring System (NTOMS), which will permit the ongoing assessment of substance abuse treatment outcomes at the national level. National data collection activities are resource intensive, in terms of staff time as well as dollars. SAMHSA will continue to address national data collection needs, first addressing those of greatest priority to national efforts such as the National Drug Control Strategy and Healthy People 2010.

Data Collection for GPRA Reporting

SAMHSA has the necessary authority and funding to collect and report necessary data for all programs other than the Block Grants, utilizing a portion of program funds. For the block grants, the States and SAMHSA have been working in voluntary partnership for several years to develop measures that are useful to States as well as to the Federal Government. SAMHSA has been able to use set-aside funds from each block grant to develop measures and pilot their application. SAMHSA has worked with the States to urge them to report outcome data on a voluntary basis as part of their block grant application. OMB has now approved collection of a core set of information for both Block Grants. However, there is evidence that without infrastructure funding, many States may not be able to take the essential next step of generating and reporting these data for mental health, substance abuse, or for both. Current efforts will develop better information on State data infrastructure needs.

Evaluation

SAMHSA has implemented an evaluation policy that defines an integrated model of evaluation and planning. The formulation of programmatic and evaluation priorities includes consultation with SAMHSA staff with evaluation expertise who are able to provide a technical advisory response, Center Advisory Councils, and other external experts in the fields of evaluation and service delivery. Results from completed and ongoing evaluations continue to provide useful information for program planning and policy development, as the agency continues to refine its priorities and objectives.

Conclusion

SAMHSA has established a framework for carrying out its performance measurement responsibilities, can report data evidencing significant performance for a number of important programs, and has processes in place to obtain many of the data that are missing or have not yet been generated for new programs. Moreover, we are successfully collaborating with our stakeholders, partners and grantees to improve performance measurement. Part II contains reports on program performance as the agency continues to move forward in its implementation of GPRA.

PART II - PROGRAM PLANNING AND ASSESSMENT

Introduction: Program Strategy and Budget Structure

As mentioned in the introduction to this Plan, a particular challenge for SAMHSA following the 1992 reorganization was to develop and implement a program strategy and budget structure consistent with its legislatively defined mission. SAMHSA's performance approach included the establishment of four major budget/program goals. Unlike SAMHSA's mission level outcomes, the four Long-Term goals reflect the outcomes of SAMHSA's programmatic activities. Each of SAMHSA's budget activities, new or existing, represents a strategy for achieving one of the four goals. SAMHSA's performance plan and performance report includes activities recently initiated or currently underway and is presented in relation to the four programmatic goals. Within each budget line, one or more activities implements the program intent. Each major activity also has a program goal. At the activity level, SAMHSA has chosen the option, permitted by OMB Circular A-11, of utilizing quantifiable performance indicators to measure an activity goal that is not self-measuring.

SAMHSA's Knowledge Development and Application budget line consists of a large number of specific activities. Including specific measures and interim data on all of those activities in a performance plan and report would produce a document of excessive length and detail. Accordingly, SAMHSA has chosen certain representative activities to report and update on an annual basis until the first group of these activities is ready for final reporting in FY 2001. As these and other activities are

completed and final data have been analyzed, SAMHSA will report results in the GPRA report. The tables at the beginning of each Center section show the schedule for completion and reporting of time-limited and ongoing activities.

Aggregation of Program Activities in Annual Performance Plan

SAMHSA's program activities include several which cut across organizational lines, and several which are particular to a single agency component. Accomplishments in either case are summarized in Section 1.4 of this plan. SAMHSA's activities are reported by associated budget line item and pertinent GPRA goal in the following order:

Substance Abuse Treatment

2.1 SAPT Block Grant (Goal 1)
2.2 Targeted Capacity Expansion (Goal 2)
2.3 Adult Marijuana Users (Goal 3)
2.4 Wraparound Services (Goal 3)
2.5 Teen Marijuana Users (Goal 3)
2.6 Starting Early/Starting Smart (Goal 3)
2.7 Addiction Technology Transfer (Goal 3)

Substance Abuse Prevention

2.8 Prevention Set-aside from SAPT Block Grant (Goal 1)
2.9 SYNAR Amendment (Goal 1)
2.10 State Incentive Grants (Goal 2)
2.11 Community Coalition (Goal 2)
2.12 Predictor Variables (Goal 3)
2.13 Starting Early/Starting Smart (Goal 3)
2.14 Youth Connect (Goal 3)
2.15 Workplace Managed Care (Goal 3)
2.16 National Clearinghouse for Alcohol and Drug Information (Goal 3)
2.17 Youth Substance Abuse Prevention Initiative (Goal 3)
2.18 Application of Prevention Technologies (Goal 3)

Mental Health Programs

2.19 Mental Health Block Grant (Goal 1)
2.20 Protection and Advocacy (Goal 1)
2.21 PATH Homeless (Goal 1)
2.22 Children's Program (Goal 2)

2.23 ACCESS Homeless (Goal 3)
2.24 Employment Intervention (Goal 3)
2.25 Knowledge Exchange Network (Goal 3)
2.26 Community Action (Goal 3)

Managed Care

2.27 Managed Care (Goal 3)

Substance Abuse National Data Collection

2.28 Household Survey Expansion (Goal 4)
2.29 Drug Abuse Warning Network (Goal 4)
2.30 Drug Abuse Services Information System (Goal 4)

Substance Abuse Treatment

The mission of the Center for Substance Abuse Treatment (CSAT) is to ensure that people in need of treatment receive it, and to improve the effectiveness and efficiency of substance abuse treatment services throughout the United States. In conjunction with other Federal agencies such as the Departments of Justice and Veterans Affairs which support similar activities, CSAT's efforts contribute to achieving the National Drug Control Strategy goals including reducing the number of drug users and the health and social costs associated with drug use. CSAT relies on two programs: the Substance Abuse Prevention and Treatment Block Grant and Targeted Capacity Expansion to ensure that thousands of Americans who suffer from substance abuse problems get the best publicly funded treatment services possible, when and where they need them. CSAT also improves the effectiveness and efficiency of substance abuse treatment services through its Knowledge Development and Application Program, by bridging the gap between research and service providers in local communities.

The following are just a few highlights of our programs successes:

< CSAT increased the percentage of technical assistance events that resulted in 66% of States making systems, program or practice change. This is 16% above the 1999 target of 50%.

< In CSAT's Marijuana Treatment for Youth program, preliminary studies with five interventions have demonstrated actual reduction in marijuana use. In untreated adolescents, marijuana use typically accelerates until age 20, with out-patient treatment only reducing or leveling the slope of increasing use.

CSAT contributes to three main goals which correlate with the budget for SAMHSA. The following programs will be reported in the GPRA plan.

Goal 1: Assure Services Availability
2.1 SAPT Block Grant

Goal 2: Meet unmet and emerging needs
2.2 Targeted Capacity Expansion Including TCE-HIV and TCE Outreach

Goal 3: Bridge the gap between knowledge and practice
2.3 Treating Adult Marijuana Users
2.4 Wraparound Services
2.5 Treating Marijuana Users
2.6 Starting Early/Starting Smart
2.7 Addiction Technology Transfer Centers

All of CSAT programs and activities are included in the table below. Of these programs two programs address Goal 1 for 60 States and Territories; the Targeted Capacity Expansion program addresses Goal 2 for 85 grantees; and the Knowledge Development and Application program, addresses Goal 3 with over 100 grants and contracts.

Activity Table - Center for Substance Abuse Treatment

*An asterisk indicates that performance information is reported in the FY 2001 performance plan and report. Activities not asterisked are time-limited activities that will be reported out approximately one year following their completion. These activities are measured in a manner similar to other activities within their goal area.

	First Funded	Completed	First Reported
Goal 1: Assure Services Availability			
SAPT Block Grant	Ongoing	Ongoing	Ongoing*
State Needs Assessment Program	FY 1999	FY 2001	FY 2003*
Goal 2: Meet unmet and emerging needs			
Targeted Capacity Expansion			
TCE-General	FY 1998	Ongoing	Ongoing*
TCE-HIV	FY 1999	FY 2001	FY 2003*
TCE-HIV Outreach	FY 1999	FY 2001	FY 2003*
Goal 3: Bridge the gap between knowledge and practice			
Treating Adult Marijuana Users	FY 1996	FY 1999	FY 2001*
Wraparound Services	FY 1996	FY 1999	FY 2001*
Managed Care/Adults	FY 1996	FY 1999	FY 2001
Homelessness Prevention	FY 1996	FY 1999	FY 2001

Managed Care/Teens	FY 1997	FY 2000	FY 2002
Criminal Justice Diversion	FY 1997	FY 2000	FY 2002
Treating Teen Marijuana Users	FY 1997	FY 2000	FY 2002*
Starting Early, Starting Smart	FY 1997	FY 2001	FY 2003*
Exemplary Treatment Models	FY 1998	FY 2001	FY 2003
Women and Violence	FY 1998	FY 2003	FY 2005
Treating Methamphetamine Use	FY 1998	FY 2001	FY 2003
SA/MH in Aging Populations	FY 1998	FY 2001	FY 2003
Practice Research Collaboratives	FY 1999	FY 2001	FY 2003
Addiction Tech. Transfer Centers	FY 1998	Ongoing	Ongoing*
National Leadership Institute	FY 1997	Ongoing	Ongoing
Practice Research Networks			
Community Action Grants	FY 1998	Ongoing	Ongoing

In future plans/reports, CSAT will be adding programs and measures at the beginning of each calendar year. CSAT submissions will include the following information:

1) All active programs will be described; this is particularly true for the KDA section of this report. The Block Grant and TCE sections will remain unchanged except for updating the data.
2) Additional preliminary data will be included for recently funded programs.
3) Final data should be available in the FY 2003 submission.

The Center for Substance Abuse Treatment is in the process of developing additional measures to examine the scope and impact of the activities contained within three programs: Block Grant, Targeted Capacity Expansion, Knowledge Development and Application. In addition, we are making strides in the development of a center-wide Management Information System that will facilitate program management through data. These developments are driven from the bottom-up, i.e. the program level, and will be completed over the next fiscal year. The use of data for management is not new to Public Health; however, Substance Abuse Treatment has made policy changes to make improvements in this area. CSAT is committed to the use of data for management and accountability and is actively moving to meet this goal along with the SAMHSA GPRA Goals. These efforts should, in the near future improve CSAT's reporting mechanism for GPRA.

2.1 Program Title: Substance Abuse Prevention and Treatment (SAPT) Block Grant - Annual Report of Ongoing Program

Performance Goals *Goal 1: Assure Services Availability*	*Targets*	*Actual Performance*	*Refer-ence*

1. Number of clients served and outcome indicators: Number of Clients served: Outcome Indicators:	FY 01:1,635,422 FY 00:1,525,688 FY 99: N.A., first included in FY 2001	FY 01:TBR 8/01 FY 00:TBR 8/00 FY 99: TBR FY97: 1,200,000**	B115
Increase % of adults receiving services who:	FY 01:40%* FY 00: Establishing baselines FY 99: N.A.; first included in FY 2000.	FY 01:TBR 8/01 FY 00:TBR 8/00 FY 99: N.A.	
(a) were currently employed or engaged in productive activities;	FY 01: 40%* FY 00: Establishing baselines FY 99: N.A.; first included in FY 2000.	FY 01:TBR 8/01 FY 00:TBR 8/00 FY 99: N.A.	
(b) had a permanent place to live in the community;	FY 01: 40%* FY 00: Establishing baselines FY 99: N.A.; first included in FY 2000.	FY 01:TBR 8/01 FY 00:TBR 8/00 FY 99: N.A.	
(c) had no/reduced involvement with the criminal justice system. Percent decrease in	FY 01: 40%* FY 00: Establishing baselines FY 99: N.A.; first included in FY 2000.	FY 01:TBR 8/01 FY 00:TBR 8/00 FY 99: N.A.	
(a) Alcohol use;	FY 01: 40%* FY 00: Establishing baselines FY 99: N.A.; first included in FY 2000.	FY 01:TBR 8/01 FY 00:TBR 8/00 FY 99: N.A.	
(b) Marijuana use;	FY 01: 40%* FY 00: Establishing baselines FY 99: N.A.; first included in FY 2000.	FY 01:TBR 8/01 FY 00:TBR 8/00 FY 99: N.A.	
(c) Cocaine use;	FY 01: 40%* FY 00:Establishing baselines FY 99: N.A.; first included in FY 2000.	FY 01:TBR 8/01 FY 00:TBR 8/00 FY 99: N.A.	
(d) Amphetamine use (e) Opiate use *<u>Note:</u> Targets set according to expectations based upon TEDS and NTIES Evaluation data. ** FY 97 baseline admissions is from the TEDS data.	FY 01: 40%* FY 00: Establishing baselines (Approval to collect data on a voluntary basis from States was received on 8/99) FY 01: 40%* FY 00: Establishing baselines FY 99: N.A.; first included in FY 2000.	FY 01:TBR 8/01 FY 00:TBR 8/00 FY 99: N.A.	

2. Through TOPPS II activity, reach agreement on standardized approach within one year of grant funding and implement voluntary performance outcome measures for SAPT block grant across States	FY 01:Maintain at 19 FY 00:Maintain at 19 FY 99: Not Applicable; First included in FY 2000.	FY 01:TBR 8/01 FY 00:TBR 8/00 FY 99: Baseline 19	B115
3. Increase the number of States and territories reporting performance measures in their SAPT Block Grant . (Measure 3 added to incorporate outcome measures in State plans)	FY 01: 48 FY 00: 19 FY 99: Not Applicable; First included in FY 2000.	FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99 Baseline: No States	B115
4. Increase % of States that express satisfaction with TA provided (Formerly Measure 3 in FY 2000)	FY 01: 95% FY 00: 90% FY 99: 85%	FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99: 96% Satisfied and Very Satisfied combined FY 98 Baseline: New survey, 0 States	B115
5. Increase % of TA events that result in systems, program or practice change (Formerly Measure 4 in FY 2000)	FY 01: 75% FY 00: 70% FY 99: 50%	FY 01: TBR 8/ 01 FY 00: TBR 8/00 FY 99: 66%; 16% above target FY 98: Baseline: Zero; No survey conducted.	B115
6: Increase % of BG applications which include needs assessment data from CSAT needs assessment program. (Reinstated - Formerly Measure 2 FY 1999; dropped in FY 2000)	FY 01: 85% FY 00: 80% FY 99: 75%	FY 01: TBR 8/ 01 FY 00: TBR 8/00 FY 99: 72%; 3% below target FY 98: 72% FY 97 Baseline: 62%	B115
Total Funding:	**1998: $1,360,107,000** **1999: $1,585,000,000** **2000: $1,600,000,000** **2001 Req:$1,631,000,000**	**(These are totals before deducting 20% Prevention Set-Aside)**	

2.1.1 Program Description, Context, and Summary of Performance

The program was established in 1981 as a consolidation of earlier categorical programs in community mental health and substance abuse services. A 1990 study recommended that 1) due to disparities in the amounts allocated to mental health and substance abuse, the block grant be split in to two separate block grants, 2) the allocation should be based on the proportion of poor persons in the State, and not the entire State population, and 3) there should be an adjustment for cost of services because some States had higher costs than others. Thus, in 1992 the BG allotment was split into two portions, one for mental health and one for substance abuse. (P.L. 102-321 the ADAMHA Reorganization Act).

This program provides funding to 60 States and territories in support of treatment and prevention services for persons at risk of or abusing alcohol and other drugs. The program is the cornerstone of the States' substance abuse programs, accounting for 40 percent of public funds expended for treatment and prevention (FY 1995). In 19 of the 60 States and territories (FY 1997), the grant

provides the majority of funding available to support substance abuse treatment services.

This is a vital and indispensable program to State efforts to maintain viable treatment capacities and to respond to the needs of those citizens who are greatest risk for alcohol and drug abuse. CSAT has provided funding to over 7000 substance abuse treatment providers. As can be seen from the following set of trend data (Treatment Episode Data Set 1997 Report SAMHSA, 1999) the substance abuse Block Grant program has assisted in funding between 1.4 and 1.6 million admissions per year since 1992.

In addition to the direct funding of services, CSAT is using a portion of the 5% set-aside toward the development of outcome measures to assist the States in monitoring and evaluating substance abuse treatment services, the collection of needs assessment data to assist in the planning and resource allocation at the State level, and a broader range of technical assistance activities.

Program Performance and Preliminary Data: The data for this program can be divided into process measures and performance measures. By examining both the process and the outcome measures we can see movement toward outcomes as well as preliminary data available on the actual performance measures.

There are six performance measures. These measures are discussed in detail in the Goal by Goal Section. Targets have been set for the voluntary measures relying on existing data such as the Treatment Episode Data Set (TEDS) and published literature about the performance of clients in treatment.

To date, the exact client counts in block grant funded facilities are developmental. States are working towards unduplicated counts. The majority of the states should be able to report unduplicated counts by FY 2001. A proxy of service utilization is “admissions” for substance abuse treatment submitted in the FY 1999 BG applications. These FY 1996 admissions may count the same person more than once if he/she had more than one admission. The FY 1996 admission data, however, are the best data currently available:

< Primary diagnosis-alcohol 898,733
< Primary diagnosis-drug 937,694
< Poly drug use 414,728

TOPPS II initiative has now produced common core data items, which are being piloted in 19 States. CSAT has completed the incorporation of voluntary outcome performance measures into the FY 2000 SAPTBG application, and has received approval from OMB for the collection of the data on a

voluntary basis. The final consensus-driven items are included in Appendix B1.

Preliminary data are reported in the tables above and discussed in section 2.1.2. when available. The voluntary measures (Measures 2a-3e) have just been instituted and data are not currently available.

2.1.2 Goal-by-Goal Presentation of Performance

Measure 1: Core outcome indicators for adults and adolescents receiving substance abuse treatment will be reported voluntarily by those States that are able to do so as part of the FY 2000 block grant application, as follows:

Increase % of adults/adolescents receiving services who:
(a) were currently employed or engaged in productive activities
(b) had a permanent place to live in the community
(c) had no/reduced involvement with the criminal justice system.

Percent decrease in:
(d) use of specific substances (alcohol; marijuana, cocaine; amphetamine; opiates)

Rationale: These items are standard measures which are often reported in evaluation studies that examine treatment effectiveness. National Treatment Improvement Evaluation Studies (NTIES) has used these indicators and it is reasonable for these items to be used as proxy measures for setting targets. NTIES has found that over time substance abuse treatment programs cut primary drug use in half, reduced related medical visits, and reduced in-patient mental health visits. Treatment also reduced criminal activity by as much as 80%. In addition, criminal activities declined significantly among NTIES clients for:

- Selling Drugs (-78%),
- Shoplifting (-82%),
- Beating someone up (-78%),
- Arrests for any crime (-64%), and
- receiving most income from illegal sources (-48%).

It is also important to note here that the TEDS data are used as proxy data for setting the targets for Measure 1, number of clients served. Also it is important to note that although it appears that admissions to treatment are declining, the number of clients in the TEDS admissions does not represent the total national demand for substance abuse treatment, nor prevalence of substance use in the general population.

Data Source and Validity of Data: Data will be reported by States in December 2000 indicating sources within states.

Baseline: Baseline data will be available in the fall of 2000.

Target: FY 2001 40% increase in appropriate behaviors

Progress Update: August 2000.

Measure 2: Through TOPPS II activity, reach agreement on standardized approach within one year of funding and implement voluntary performance outcome measures for SAPT block grant across States

Rationale: To date, the identification of performance and outcome measures for the substance abuse block grant programs has been identified as a critical need. The identification and acceptance of the outcome measures have been accomplished through a collaborative partnership. Such an approach requires time to implement and complete; the Treatment Outcome Pilot Projects II (TOPPS II) and other activities are in place to accomplish this goal.

Data Source and Validity of Data: Ultimately, each State is responsible for the methodology of data collection and analysis. As with earlier performance indicators, States will report this information in the grant application. Reliability and validity will be assessed through project monitoring and periodic compliance reviews of project records. In addition, quarterly steering committee meetings will be held to address and monitor the development of this project.

Baseline: FY 1997, no measures.

Target: FY 98, target was partially met when all 19 states agreed on the standardized outcomes and are in the process of implementation.

Progress Update: Measure 2 is needed to contribute to the development of core measures of substance abuse for State Block Grants. Initial TOPPS projects were funded at the end of FY 1997; TOPPS II projects were funded in September, 1998. Information domains and measures have been identified and instruments for data collection have been decided on. Agreement on domains for data collection and some standards for methodology have been developed.
To date, a 31 item inter-State core data set has been developed by the TOPPS II Steering Committee to measure substance abuse treatment effectiveness in SAPT BG funded treatment programs. This inter-State core data set has been approved through a consensus process involving all 19 TOPPS II Project States. The TOPPS II inter-State core data set has incorporated the four outcomes items proposed in the revised SAPT BG uniform application for FY 2000. These four items measure employment status, housing status, criminal justice, and alcohol and drug use.

The inter-State evaluation design for TOPPS II participants will be a pre-post test design that collects data at client intake, discharge and again at follow-up to allow treatment providers the opportunity to assess the causal links between program process and client outcomes and to monitor common substance abuse treatment effectiveness data measures across various State management information systems.

FY 1997 baseline	FY 1998 Target	FY 1998 actual	FY 1999 Target	FY 2000 Target
0 outcome measures tested; preliminary discussions held	Outcome domains selected; instrument selection underway	General agreement on domains has been reached with the states; work is continuing	Instruments will be selected and pilot-testing begun in selected states.	Initial data will be collected and analyzed; reliability and validity will be assessed in the participating states.

Measure 3: Increase the number of states reporting performance measures in their SAPT Block Grant.

Rationale: As an infrastructure development activity, TOPPS II process will develop an approach that is viable for all of the States. Complete adoption by all States will take some time but annual progress will be monitored. Adoption by the States of the measures once the necessary development work has begun to be completed, is the appropriate outcome measure for this critical activity.

Data Source and Validity of Data: Data will be collected by community-based providers using standard instruments administered to the clients by trained interviewers.

Baseline: FY 1999, no states

Target: Within one year following completion of the activity (FY 2001), 50 States, 8 territories and 2 tribes will have adopted the standardized approach.

Progress Update: Currently the block grant application has been modified and approved by OMB to include the collection of this critical information. As this is a new activity. We do not have data at present but will in the FY2000 performance report. Currently about 20% of the applications include the voluntary measures. In addition, all 19 States of the TOPPS II project have adopted these measures. We will continue to monitor this information as is necessary and report annually on the new targets which have been defined.

Measure 4: Increase proportion of States that express satisfaction with technical assistance provided.

Rationale: Customer satisfaction is a good measure of the responsiveness and utility of SAMHSA's

information and technical assistance efforts. A global satisfaction measure that includes these components has been developed, implemented and will continue to be used in future years.

Data Source and Validity of Data: Data source is a survey of the States. Reliability and validity was assessed by the independent contractor as part of survey design, development, and pilot implementation

Baseline/Target:

FY 1998 baseline	FY 1999 Target	FY 1999 actual	FY 2000 Target	FY 2001 target
0%	85%	96% satisfied and very satisfied combined	90%	95%

A customer feedback system was designed and piloted with 14 States in FY 1998. Based upon feedback from informal telephone interviews conducted by an independent contractor indicating a very high degree of satisfaction with the technical assistance, setting the FY 1999 target at 85%, and FY 2000 target at 90% appeared reasonable. 42 of the 60 States and Territories were surveyed between November of 1998 and November of 1999 in order to determine the level of satisfaction with CSAT's Technical Assistance.

Progress Update: When the two highest categories (satisfied and very satisfied) are combined the overall satisfaction rate is 96%. Sixty-seven percent (67%) of the 42 states surveyed reported being very satisfied with the technical assistance provided. This does not meet our target of 85% however, in FY 2000 we would like to improve the very satisfied rating to 90%.

Measure 5: Increase percentage of TA events that result in appropriate systems, program, and/or practice change(s).

Rationale: The impact of technical assistance is measured by positive changes that occur (and are maintained) in those systems, programs or practices addressed during the course of the technical assistance activity. Technical assistance which is off-point, too esoteric for implementation, or otherwise not practical will not result in implementation of improvements in the treatment system.

Data Source and Validity of Data: Data sources which are consonant with the selected measures have been selected and included in a survey and the validity and quality of data have been assessed in the survey design and development process.

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Baseline/Target:

FY 1998 baseline	FY 1999 Target	FY 1999 actual	FY 2000 Target	FY 2001 target
0%	50%	66%	70%	75%

Progress Update: As part of a survey of States and Territories, 66% reported making a change in their system as a result of Technical Assistance received from CSAT. SAMHSA, in partnership with the field, began developing appropriate measures and data sources for this activity in FY 1998 as well as a methodology to ensure that the data are gathered without significant delay or burden to the recipients of technical assistance. With regard to the SAPT BG, a system for ongoing feedback on the impact of CSAT technical assistance resources on State systems is under development. A component of that effort will be followed up several months after the delivery of technical assistance to determine impact. OMB has approved the survey form regarding systems impact for telephone data collection. It will be implemented through the use of an independent contractor. The development of an ongoing process of surveying State directors (SSAs) several months after the delivery of technical assistance is well underway, using this methodology.

The following quotations from State directors help to illustrates some of the impact

"First it increased collaboration across multiple systems for one of our counties. Also, the data integration technical assistance helped us demonstrate the efficiency of our system. This led to a budget increase by the legislature of $30 million dollars. This happened because we had good research that proves that what we are doing save lots of acute care and psychiatric care. For every 2.5 million spent by us, the state saves 4.8 million in other health care costs."

"It has improved our ability to improve services to Medicaid populations and has bolstered our changes that are underway."

"The technical assistance has helped to get training which has helped us get results"

Measure 6: Increase the percentage of BG applications which include needs assessment data from CSAT needs assessment program.

Rationale: One of the statutory requirements for the SAPT block grant is that states base their planning for the use of BG funds on needs assessments within the state. For the past five years, CSAT has provided direct technical assistance (in dollars and personnel) to Single State Agencies to engage in State-based needs assessment activities. The block grant application requires that States be able to array need-for-treatment data using sub-state planning regions as the basic unit of analysis. Every State, and most territories have now received at least one award in this area, and each State which has

completed a core of basic studies is encouraged to use those State-generated data sets as the basis of their block grant applications. A measure of the success of this activity is the proportion of states that do include this information; targets are based on the proportion of States who have completed at least an initial round of needs assessment studies.

Data Source and Validity of Data: Data are being collected via the Block Grant Application System. A recent GAO report identified some problems with the completeness and accuracy of the data reported by the States and recommended that CSAT develop a plan for making improvements. CSAT developed a four step action plan and is implementing it at this time. In brief, validity of the data under this system is reviewed as part of the approval of funding and specific feedback provided to individual States. In addition, reviews of the data are done as part of a cyclical compliance review process required by statute.

Baseline/Target:

FY 1997 baseline	FY 1998 Target	FY 1998 actual	FY 1999 Target	FY 1999 actual	FY 2000 Target	FY 2001 target
62%	65%	72%	75%	72%	80%	85%

Progress Update: The proportion of States that submitted needs assessment data as part of their applications exceeded the FY 1998 target. In the coming year, CSAT will continue to work collaboratively with the States to increase the proportion of those who have completed their initial needs assessment studies to report that data in their applications. Forty States currently have contracts from CSAT to conduct needs assessment studies in support of their block grant planning and reporting; 23 of those States have successfully completed one round of studies and are conducting a second set at this time. The success of this ongoing program is reflected in the state's ability to provide the data required by the statute.

2.2 Program Title: Targeted Capacity Expansion-Annual Report of Ongoing Program: Performance Measures

Performance Goals *Goal 2: Meet emerging and unmet needs*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase the number of clients served	FY 01: 25,200 FY 00: 23,073 FY 99:8,700	FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99: 3,200 preliminary data	B111

2. Increase % of adults receiving services who: (a) were currently employed or engaged in productive activities; (b) had a permanent place to live in the community; (c) had no/reduced involvement with the criminal justice system. (d) experienced no/reduced alcohol or illegal drug related health, behavioral, social, consequences (e) increase percent of clients who had no past month substance use *In previous plan a place holder existed stating Improvement on SAMHSA Core Client Outcomes. Having receive OMB approval we have included the actual items. Note: *See page 36 for reference.	 FY 01: 40% FY 00: 30% FY 99: Not applicable* FY 01: 40% FY 00: 30% FY 99: Not applicable* FY 01: 1 days in jail FY 00: 2 days in jail FY 99: Not applicable* FY 01: 40% FY 00: 30% FY 99: Not applicable* FY 01: 40% FY 00: 30% FY 99: Not applicable*	 FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99 Preliminary Baseline:17.5% FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99 Preliminary Baseline: 84.6% housed* FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99 Preliminary Baseline: 2.45 days FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99 Preliminary Baseline: 20% FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99 Preliminary Baseline: 0%	B111
Total Funding:	**1998: $ 24,732,000** **1999: $ 55,089,000** **2000 : $114,307,000** **2001 Req:$163,161,000**		

Process Measures*

Performance Goals *Goal 2: Meet emerging and unmet needs*	*Targets*	*Actual Performance*	*Refer-ence*
1. Number of Grantees	FY 01:131 FY 00:131 FY 99: 41	FY 01: TBR 8/01 FY 00: 131 preliminary FY 99:41 FY 98: 41	B111
2. Number of Funded Grantees that (a) Developed Protocols on schedule	FY 01:131 FY 00:131 FY 99:41	FY 01: TBR 8/01 FY 00: 131 or 100 % of Target FY 99: 41 or 100% of Target	
(b) Began GPRA data collection on schedule	FY 01:131 FY 00:131 FY 99:41	FY 01: TBR 8/01 FY 00: TBR 8/02 FY 99: 18 or 43% of target	
(c) Ended GPRA Data Collection on schedule (Will not occur until 3 years into project)	FY 01:41-original grantees FY 00: Not applicable FY 99: Not applicable	FY 01: TBR 8/01 FY 00: Not applicable FY 99: Not applicable	
(d) Began Preliminary Data (Analysis on schedule)	FY 01: 131 FY 00:131 FY 99: 41	FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99: 18 or 43% of target	
(e) Completed Analysis on schedule (This should not occur until completion of data collection)	FY 01:41-original grantees FY 00: Not applicable FY 99: Not applicable	FY 01: TBR 8/01 FY 00: Not applicable FY 99: Not applicable	
(f) Submitted Final report on schedule	FY 01:41-original grantees FY 00: Not applicable FY 99: Not applicable	FY 01: TBR 8/01 FY 00: Not applicable FY 99: Not applicable	

* Process measures were not included in previous submissions

2.2.1 Program Description, Context, and Summary of Performance

The Targeted Capacity Expansion (TCE) Grant Program began in 1998 to address gaps in treatment capacity by supporting rapid and strategic responses to demand for substance abuse treatment services. The response to treatment capacity problems included communities with serious emerging drug problems as well as communities with innovative solutions to unmet needs. Grantees encompass a wide variety of sources, including the following:

- local governmental entities, cities, towns, and counties;
- regional governmental entities; and
- State, Territories, and Indian Tribal Governments.

Most grantees may be classified into one of five categories, based on the new and emerging needs of these specific populations they serve: women, Native Americans, adolescents, methadone/injection drug users, and criminal justice involvement. Some grantees have identified other populations such as the cognitively impaired and/or physically disabled individuals and those diagnosed with co-occurring disorders. Subgroups exist within each of the targeted populations including racial and ethnic minority groups, homeless individuals, and persons living with HIV/AIDS.

Applications are made to CSAT requesting funds to provide services that address emerging or unmet need in any community across the United States. Applicants must document the emerging or unmet need in their proposal, which is then reviewed by peers and given a priority score. Based on these ratings the project may get funding. In addition, the Congressional Black Caucus earmarked several million dollars for HIV/AIDS to the African American communities including adolescent as well as women and their children. These programs have been incorporated into the Targeted Capacity Expansion Program budget line.

The current Targeted Capacity Expansion Program awards have been classified into one of five groups based on the specific population they serve. They fit into these categories with some overlap:

Population Clusters

- Women (15 grantees)
- Native Americans (9 grantees)
- Adolescents (6 grantees)
- Methadone/Intravenous Drug Users (5 grantees)
- Criminal Justice (5 grantees)
- HIV/AIDS (25 grantees)

Additional populations have also been identified: Hispanic/Latino, African American, Alcohol and Dually Diagnosed.

Program Performance and Preliminary Data: The number of grantees for this program was targeted at 41 in 1998 and has been achieved. Additional process measure outcomes indicate that 100% of the 1999 and 2000 target has been met for the development of study protocols, and 43% of the target has been reached regarding the process of collecting data. Finally, 43% of the target has been reached with respect to the preliminary analysis of data enabling the program and CSAT to report preliminary data regarding the initial progress on the SAMHSA Core Client Outcome in this report. These data will be updated regularly in future submissions. Finally in FY 2000 an estimated 23,073 persons will have been served, with future estimates that predict significant increases.

Most projects are now operational and actively serving clients. Enrollment is consistent with

projections at most sites. Where enrollment is below projections, staff are devising strategies to increase the number of clients being served. Evaluation plans are being implemented and data are being collected at those projects which have started serving clients.

Preliminary analysis indicates that some clients to be served have received services, however, number of enrollments vary. Performance measures will include the SAMHSA GPRA Core Clients Outcome Measures. The GPRA Core Clients Outcome Tool has just received OMB approval (10/18/99), so limited data are available.

Table 2.2 indicates the baseline percentages for those clients on which GPRA data had been collected to date. As more data are collected, (including the follow-up data) these will be reported. While this data are preliminary and represent only 486 of the 3000 clients served they are useful indicators of baseline characteristics of clients being served in this program.

2.2.2 Goal-by-Goal Presentation of Performance

Measure 1: Numbers of Clients Currently Being Served:

Rationale: This item is a standard measure which is often reported in evaluation studies that examine treatment effectiveness. With regard to accountability, this item is an important monitoring factor from which program performance can be estimated

Data Source/Validity: Data are derived from monthly reports submitted to the Government Project Officer. These data are also included in the programs submission of their data sets to CSAT

Baseline: FY 1999, 3,200 based on preliminary data

Target: FY 2000, 23,073; FY 2001: 25,200

Progress Update: Based on preliminary data that cover the first six months of start up, operationalization, and implementation of the projects (October, 1998-June 1999), the TCE projects have served approximately 3,200 clients.

Data are still sketchy at this point since we were in the initial phase of the program, and data collection could not begin until OMB approval of the GPRA data collection tool, and site specific issues were resolved. The next quarterly progress reports should show a significant jump in the volume of data available for this program. This prediction is supported by verbal feedback obtained from the evaluators at the TCE Cross-site Evaluation meeting (December 1-3 1999).

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Measure 2: Increase the percentage of adults receiving services who:

(a) were currently employed or engaged in productive activities;
(b) had a permanent place to live in the community;
(c) had no/reduced involvement with the criminal justice system.
(d) experienced no/reduced alcohol or illegal drug related health, behavioral, social, consequences
(e) increase percent of clients who had no past month substance use

Rationale: These items are standard measures which are often reported in evaluation studies that examine treatment effectiveness. In addition, these items are generally collected at admission by the treatment program in order to assess an individuals substance abuse problem. NTIES has studied several of these indicators and has found that over time substance abuse treatment cut primary drug use in half, reduced related medical visits, and in patient mental health visits. Treatment also reduced criminal activity by as much as 80%. Criminal activities declined significantly among NTIES clients for: Selling Drugs (-78%), Shoplifting (-82%), Beating someone up (-78%), Arrests for any crime (-64%), and receiving most income from illegal sources (-48%).

Please note that the current baseline for (b), had a permanent place to live in the community, is based on preliminary data where (n=400). When the data is complete (n=3,000), the number housed with a permanent place to live in the community is forecast to significantly decrease. Researchers anticipate that the when the program enters its maturity and more data is available, the number of persons housed will significantly decrease justifying the current target levels.

Data Source and Validity of Data: The data for this measure are gathered using the SAMHSA Core Client Outcomes GPRA Tool. Each Center has a tool which addresses as appropriate their population with regards to client outcomes. CSAT has instituted this tool across all its new discretionary KD programs. The validity of the data is monitored by several data coordinating centers assigned to each program and whose responsibility it is for data collection, verification, cleaning, and delivery to CSAT these GPRA items.

Baseline: FY 1999 (NOTE: Preliminary Data-Not all sites have reported)

(a) were currently employed or engaged in productive activities; 17.5%
(b) had a permanent place to live in the community; 91.8%
(c) had no/reduced involvement with the criminal justice system as measured by days in Jail 2.45 days
(d) experienced no/reduced alcohol or illegal drug related health, behavioral, social, consequences 20%
(e) increase percent of clients who had no past month substance use 0%

Target: FY 2000 30% Increase from baseline to follow-up.

Progress Update: Approval to collect these measures was just received in October of 1999 from OMB. A limited number of grantees have collected these data on a voluntary basis. These preliminary results are presented in the table above. It is important to note that these data are baseline and do not represent follow-up of change scores. It is CSAT's intention to collect this information a baseline, 6 months and 12 months post baseline. All data that is available at each submission cycle will be included in the plan/report.

Knowledge Development and Application Program

Having described the programs of SAPTBG and TCE the focus will now shift to the Knowledge Development and Application (KDA) Program portfolio . Unlike the Block Grant and Targeted Capacity Expansion program which have many of grantees under one program, the KDA program has a variety of projects each of which has a relatively small group of grantees. Currently the portfolio contains 18 projects. This portion of the GPRA plan/Report will focus on five of these projects. In the FY 2002 submission cycle all KDA activities will be included and discussed. The FY 2002 Performance Plan and FY 2002 Performance Report will include a report of all FY 1996 KD&A programs completed in FY 1999, and will include summary information regarding FY1997, FY1998, FY1999, and FY 2000 KD&A programs.

2.3 Program Title: Treating Adult Marijuana Users (Interim Report): Performance Measures

Performance Goals *Goal 3: Bridge the gap between knowledge and practice*	*Targets*	*Actual Performance*	*Reference*
1: Submit two clinical intervention manuals with lessons learned This measure will be dropped in future submissions due to its completion	FY 00: Not applicable FY 99: Manuals submitted	FY 00: Not applicable FY 99: Manuals were completed by 1999 FY 98 Baseline: No manuals	B97
2: Clients provided 12 weeks of treatment will have better outcomes than those provided 6 weeks	FY 01: Not applicable FY 00: 12 weeks vs 6 weeks of treatment FY 99: Not applicable	FY 01: Not applicable FY 00: TBR 8/02 FY 99: Not applicable FY 98 Baseline: TBR 8/00	B97
Total Funding:	**1996: $1,300,000** **1997: $1,680,000** **1998: $1,844,000** **1999: (Prg. Finished)**		

Process Measures*

Performance Goals *Goal 3: Bridge the Gap between Knowledge and Practice*	*Targets*	*Actual Performance*	*Refer-ence*
1. Number of Grantees	FY 01: 5 FY 00: 4 FY 99: 3	FY 01:TBR 8/01 FY 00:TBR 8/00 FY 99: 3	B97
2. Number of Funded Grantees that (a) Developed Protocols on schedule	FY 01:5 FY 00:4 FY 99:3	FY 01:TBR 8/01 FY 00:TBR 8/00 FY 99: 3 or 100% of Target	
(b) Began data collection on schedule	FY 01:5 FY 00:4 FY 99:3	FY 01:TBR 8/01 FY 00:TBR 8/02 FY 99: 3 or 100% of target	
(c) Ended GPRA Data Collection on schedule Will not occur until 3 years into project	FY 01:3-original grantees FY 00: Not applicable FY 99: Not applicable	FY 01:TBR 8/01 FY 00: Not applicable FY 99: Not applicable	
(d) Began Preliminary Data Analysis on schedule	FY 01:5 FY 00:4 FY 99: 3	FY 01:TBR 8/01 FY 00:TBR 8/00 FY 99: 3 or 100% of target	
(e) Completed Analysis on schedule This should not occur until completion of data collection	FY 01:3-original grantees FY 00: Not applicable FY 99: Not applicable	FY 01:TBR 8/01 FY 00: Not applicable FY 99: Not applicable	
(f) Submitted final report on schedule	FY 01:3-original grantees FY 00: Not applicable FY 99: Not applicable	FY 01:TBR 8/01 FY 00: Not applicable FY 99: Not applicable	

* Process measures were not included in previous submissions.

2.3.1 Program Description, Context, and Summary of Performance

The Marijuana Treatment Project (MTP) otherwise known as the Multi-site study of the Effectiveness of Brief Treatment for Cannabis Dependence, began in 1996 and is a 3 year, randomized clinical trial to investigate the effectiveness of brief interventions for individuals who are dependent on cannabis. The project addresses the most commonly abused illicit substance in the United States, and is comparing two focused treatments for dependent individuals from differing socioeconomic and racial backgrounds. Findings from studies such as the NIMH Epidemiological Catchment Area Survey and the National Co-morbidity Study indicate that cannabis dependence is the most common form of dependence associated with illicit drugs. In addition, recent surveys of publicly funded drug treatment programs-the Drug Abuse Treatment Outcome Study (DATOS) and the National Treatment Improvement Evaluation Study (NTIES) found that a large percentage of admissions reported the primary drug problem for which they sought treatment was marijuana use or marijuana in combination with alcohol. However, despite the large number of people seeking treatment there is no consensus within the scientific or clinical community about the type or intensity of treatment that is optimally effective.

The program is being conducted at three collaborative centers employing a common protocol and seeks to answer two primary questions: (1) Are focused interventions any more effective than no treatment; and (2) Does a 12 week treatment produce better results than a 6 week treatment?

Program Performance and Preliminary Data: As noted in the table above data protocols have been developed, collection of data has begun and analysis is continuing. More specifically, the end of treatment evaluation and the 4-month evaluation have been completed. The 9 month follow-up has been completed and is being analyzed. A 15 and 21 month follow-up is in implementation for data collection. At this point this latter evaluation will be abbreviated and conducted via telephone. It should be noted that outcomes of measure 1 will only be determined at the 4-month follow-up evaluation.

2.3.2 Goal-by-Goal Presentation of Performance

Measure 1: Coordinating Center will submit copies of the two clinical intervention manuals, with annotations of "lessons learned" during the conduct of the field portion of this project.

Rationale: In addition to generating findings on the relative effectiveness (or lack thereof) of brief interventions on marijuana users, this project expects to generate one or more intervention models that can be disseminated to clinicians throughout the country, assuming that the findings are positive. Two intervention manuals, and associated annotations, will be delivered. These products will be reviewed for possible national dissemination, expanded clinical training, and further evaluation of the impact that brief interventions might have in addressing critical treatment needs. The reason for this measure is that clear and well defined documentation of programmatic activities and productivity are critical

Data Source and Validity of Data: Project records will document activities of the Coordinating Center.

Baseline: FY 1998, no manuals.

Target: FY 1999, manual was completed in August 1998 and is in the SAMHSA review process for publication.

Progress Update: Measure 1 Accomplished: Manuals were completed in August, 1998. They are being reviewed and dissemination plans developed. Completion of this activity was accomplished ahead of schedule.

Measure 2: Across subpopulations, clients provided 12 weeks of treatment will have better outcomes than those provided 6 weeks of treatment.

Rationale: As indicated previously, some limited research in this area indicates that 12 weeks of treatment has better results than 6 weeks but the individuals involved in those studies did not include large number of minority or female clients. Once completed, this study will provide evidence of effectiveness across a number of important subpopulations.

Data Source and Validity of Data: Data are being collected with standard instruments administered to the clients by trained interviewers.

Baseline: FY 1998, baseline, end-of-treatment, and 4 month data collection have been completed but not analyzed yet.

Target: Our hypothesis is that the experimental group will have 10% better outcomes than the control group, however, baseline data is needed before this can be established.

Progress Update: Interim performance findings should be available for next year's report. However, process data indicate that of the three grantees funded under this project, all have developed protocols and have begun to collect data. In addition, preliminary data processing is occurring with regard to data cleaning, a process whereby the data files are prepared for preliminary and final analytic work.

2.4 Program Title: Wraparound Services for Clients in Non-residential Substance Abuse Treatment Programs: Evaluating Utility and Cost effectiveness in the Context of Changes in Health Care Financing (Interim Report): Performance Measures

Performance Goals *Goal 3: Bridge the gap between knowledge and practice*	*Targets*	*Actual Performance*	*Refer-ence*
1. Coordinating Centers will develop and apply statistical models to determine which factors are associated with client retention and outcome.	FY 00: Not applicable FY 99: 100% models developed & applied	FY 00: Dropped once completed. FY 99: TBR 8/00 FY 98 Baseline: No models	B97
2. Final reports with findings, documented databases and statistical models are transmitted to CSAT, results validated.	FY 01: Not applicable FY 00: 100% reports FY 99: Not applicable	FY 01: Dropped once completed FY 00: TBR 8/00 FY 99: Not applicable FY 98 Baseline: No reports	B97
3. Clients receiving wrap-around services will have better outcomes than clients who receive substance abuse treatment alone, such as reduction in use of illicit substances, improvements on employment, housing, and education.	FY 01: Not applicable FY 00: Better outcomes with wrap-around FY 99: Not applicable	FY 01: Dropped once completed FY 00: TBR 8/02 FY 99 Baseline: TBR 8/00	B97
Total Funding:	**1996: $1,200,000** **1997: $2,339,000** **1998: $2,005,000** **1999: (Prg. Done)**		

Process Measures*

Performance Goals *Goal 2: Meet emerging and unmet needs*	*Targets*	*Actual Performance*	*Refer-ence*
1. Number of Grantees	FY 01: N.A. FY 00: 19 FY 99: 19	FY 01: N.A. FY 00: 19 or 100% of Target FY 99: 19 or 100% of Target	B97
2. Number of Funded Grantees that:			
(a) Developed Protocols on schedule	FY 01: N.A. FY 00:19 FY 99:19	FY 01: N.A. FY 00: 19 or 100% of Target FY 99: 19 or 100% of Target	
(b) Began data collection on schedule	FY 01: N.A. FY 00:19 FY 99:19	FY 01: N.A. FY 00: 19 or 100% of target FY 99: 19 or 100% of target	
(c) Ended Data Collection on schedule: (Will not occur until 3 years into project)	FY 01: N.A. FY 00: 19 FY 99: 19	FY 01: N.A. FY 00: 19 or 100% of target FY 99: 19 or 100% of target	
(d) Began Preliminary Data Analysis on schedule	FY 01: N.A. FY 00:19 FY 99: 19	FY 01: N.A. FY 00: 19 or 100% of target FY 99: 19 or 100% of target	
(e) Completed Analysis on schedule This should not occur until completion of data collection	FY 01: N.A. FY 00:19 FY 99: Not applicable	FY 01: N.A. FY 00: TBR 8/00 FY 99: Not applicable	
(f) Submitted final report on schedule	FY 01: N.A. FY00:19 FY 99: Not applicable	FY 01: N.A. FY 00:TBR 8/00 FY 99: Not applicable	

* Process measures were not included in previous submissions

2.4.1 Program Description, Context, and Summary of Performance

The goal of this program is to enhance knowledge about the effects on treatment outcomes from non-residential substance abuse treatment due to provision of wrap around services and associated costs (e.g., child care, advisory legal services, transportation, vocational training, educational services). The study population is adults admitted to treatment in any of 11 participating outpatient programs within 7

counties in Western Pennsylvania. The study covers a period of welfare reform and introduction of managed care. The study includes over 10,000 data items and multiple observation points.

The 3 year Wrap Around Services Impact Study (WASIS) began in October 1996. Data collected included participant characteristics, psychosocial history and status, and substance abuse and criminal justice histories. Clients were seen at both urban and rural locations in western Pennsylvania. Wrap around services assessed include: advisory, legal, basic needs, child care, educational family services, housing, medical, mental health, transportation, and vocational. The need for, history of, and experience with wrap around services were assessed by one or more of the following: subjective perception, objective determination, and professional confirmation. Assessments were made of system changes at the program, county and State levels (e.g. managed care and welfare reform) during the 3 year study period. Assessments for costs, adjusted for local inflation rates were also made for treatment and wrap around services.

Program Performance and Preliminary Data: If outcomes can be shown to be demonstrably improved when needs for wrap around services are met, in addition to the fundamental need for substance abuse treatment, and if those services can also be shown to be cost-effective, then the treatment field will have credible evidence with which to negotiate for the provision of those services through managed care architectures. While the data analyses are still underway, some preliminary process information is available. They include the following:

- Completed literature review
- Completed methods section of the final report
- System assessments are in the final stages of collection
- Cost analysis data have been collected and are being reviewed and cleaned

Preliminary data analysis is underway and the following preliminary outcome findings can be reported:

- The most frequently used wrap-around services were transportation, educational services, and mental health services.

- The individuals who used the wraparound services tended to be single (36.7%), male (55%), Caucasian (66.1% vs 30.9% African American) and high school graduates (78.9%). 53% had criminal justice involvement and 58.2% had income from wages.
- Predictors of acute problems from alcohol include insurance/payer difficulties, homelessness, and the lack of education.
- Contrary to belief in a dual system of treatment (public and private), there are seven subsystems with little interaction: private client, employed, insured; public client, poor, without insurance; active duty military and dependents; veterans; incarcerated; community-based with criminal justice status; and other (e.g., Native Americans, rural clients).

- Some initial assumptions changed during the study: (1) The "treatment system" is more an uncoordinated collection of providers; (2) The 2-tiered system of care mentioned above, is actually a multi-tiered collection of providers serving different populations; and (3) The "service system" is actually a web of interagency relationships.

- Examples of identified barriers to treatment include: (1) County level: interagency isolation, competition for clients and resources; agency bias against substance abuse clients; reluctance of rural counties to spend scarce county money "out of county" for services; (2) Program level: lack of knowledge of available services; inadequate services needs assessment; productivity emphasis discourages referral activities; long waits for services; and paperwork; services office-based, creating accessibility barriers; and (3) Client level: low client cognitive capacity and tolerance of paperwork; inability to focus on service-related needs in early recovery phase; crisis orientation; resentment at multiple assessments; perceived discrimination; lack of necessary conditions for service access (e.g., transportation); independent attitude and pride; need for external pressure for motivation.

Analyses will be continuing over the next year and a final report is due to CSAT in April 2000.

2.4.2 Goal-by-Goal Presentation of Performance

Measure 1: Coordinating Center will develop and apply statistical models to determine which factors are associated with client retention and outcome.

Rationale: The overarching goal of the program depends on the development of appropriate statistical models which are then applied to the clinical and programmatic databases in order to determine what factors are most strongly associated with client retention and outcome. Clearly an appropriate measure for knowledge development programs is the design, development and implementation of models that help explain the factors that may possibly improve client treatment outcomes.

Data Source and Validity of Data: Project records will document progress of statistical work.

Baseline: FY 1998, no models.

Target: FY 1999, 100% models developed and applied; FY 2000: Not applicable, one time measure which was achieved.

Progress Update: Statistical model development is proceeding and should be complete by August 2000. Application of some models for core study questions is now being conducted.

Measure 2: 100% of final reports with findings, documented databases, and statistical models are transmitted to CSAT, and the results are validated by objective review.

Rationale: Credible scientific findings must be able to withstand scrutiny by external experts who are familiar not only with the theoretical bases of the research but who are also able to independently validate the conclusions drawn by that research.

Data Source and Validity of Data: Project records will document progress.

Baseline: FY 1998, no reports.

Target: 100% of reports transmitted to CSAT with validation by objective review.

Progress Update: Data collection is complete; data bases are partially documented; complete final report is to be submitted to CSAT no later than November 2000.

Measure 3: Clients receiving wrap-around services will have better outcomes than clients who receive substance abuse treatment alone. Such outcomes include, but are not limited to, reduction in use of illicit substances, improvements on employment, housing, and education.

Rationale: According to the substance abuse treatment literature, "success" for the treatment of addiction is no longer unidimensional but is multi-dimensional. Testing models that examine outcomes for clients who have collateral needs is important to understanding outcomes. Likewise the addition of services to treat these collateral needs is also vital to improving treatment effectiveness. Thus, measuring the outcomes between two groups (those that receive wrap around services versus those that do not) is an appropriate strategy for testing program effectiveness.

Data Source and Validity of Data: Data collection with standard instruments with known reliability and validity have been administered to the clients by interviewers who have been trained to ensure consistency and validity.

Baseline: FY 1999, expected November 2000

Target: Better outcomes (such as reduction in use of illicit substances, improvements on employment, housing, and education) for those clients with wrap around services.

Progress Update: Baseline data should be available for next year's report.

2.5 Program Title: Treating Teen Marijuana Users (Interim Report): Performance Measures

Performance Goals *Goal 3: Bridge the gap between knowledge and practice*	*Targets*	*Actual Performance*	*Refer-ence*
1: Clients treated with all five models will have significantly reduced marijuana use (measure restated for clarity)	FY 01: Not applicable FY 00: Tested models all will improve outcomes. FY 99: Not applicable	FY 01: Not applicable FY 00: TBR 8/01 FY 99 Baseline: TBR 8/00	B97
Total Funding:	**1997: $1,950,000** **1998: $3,200,000** **1999: $2,486,000** **2000: 0**		

Process Measures*

Performance Goals *Goal 3: Bridge the gap between knowledge and practice*	*Targets*	*Actual Performance*	*Refer-ence*
1. Number of Grantees	FY 01: N.A. FY 00: N.A. FY 99: 4 FY 98: 4	FY 01: N.A. FY 00: N.A. FY 99: 4 or 100% of Target FY 98: 4 or 100% of Target	B97
2. Number of Funded Grantees that			
(a) Developed Protocols on schedule	FY 01: N.A. FY 00: N.A. FY 99:4 FY 98:4	FY 01: N.A. FY 00: N.A. FY 99: 4 or 100% of Target FY 98: 4 or 100% of Target	
(b) Began data collection on schedule	FY 01: N.A. FY 00: N.A. FY 99:4 FY 98:4	FY 01: N.A. FY 00: N.A. FY 99: 4 or 100% of target FY 98: 4 or 100% of target	
(c) Ended Data Collection on schedule Will not occur until 3 years into project	FY 01: N.A. FY 00: 4 FY 99: 4 FY 98: 4	FY 01: N.A. FY 00:TBR 8/00 FY 99: Not applicable FY 98: Not applicable	
(d) Began Preliminary Data Analysis on schedule	FY 01: N.A. FY 00:4 FY 99: 4 FY 98: 4	FY 01: N.A. FY 00: 4 or 100% of target FY 99: 4 or 100% of target FY 98: 4 or 100% of target	
(e) Completed Analysis on schedule This should not occur until completion of data collection	FY 01: N.A. FY 00:4 FY 99: Not Applicable FY 98: Not applicable	FY 01: N.A. FY 00:TBR 8/00 FY 99: Not applicable FY 98: Not applicable	
(f) Submitted final report on schedule	FY 01: N.A. FY 00:4 FY 99: Not Applicable FY 98: Not applicable	FY 01: N.A. FY 00: TBR 8/00 FY 99: Not applicable FY 98: Not applicable	

* Process measures were not included in previous submissions.

2.5.1 Program Description, Context, and Summary of Performance

This three year cooperative agreement began in October 1997. The 12 to 15 month recruitment and treatment phase began in spring of 1998. This program has three main goals: (1) To test the relative clinical effectiveness and cost-effectiveness of a variety of interventions targeted at reducing, eliminating marijuana use and associated problems in adolescents; (2) To evaluate the comparative effectiveness of the five interventions for all adolescents and the "match" between characteristics and interventions; and (3) To provide validated models of these interventions to the treatment field. To that end adolescent participants are assigned to one of five manualized treatment conditions:

- Motivational Enhancement Therapy and Cognitive Behavioral therapy for a total of 5 sessions
- Motivational Enhancement Therapy/Cognitive Behavioral therapy for a total of 12 sessions.
- Family Support Network (including Motivational Enhancement Therapy/Cognitive Behavioral Therapy),
- Adolescent Community Reinforcement Approach
- Multi-dimensional Family Therapy

Program Performance and Preliminary Data: Process measures include development of protocol, data collections, and preliminary analysis. These activities have been completed or begun across all four funded sites in this project. Five treatment manuals were developed for clinical practice. At this point, 1,000 youth have been screened, 606 were eligible for the study, 500 agreed to participate and to be randomized to the treatment conditions. Over 90% due for interviews have completed interviews at 3, 6, 9, and 12 months. Preliminary pilot studies with the five Cannabis Youth Treatment (CYT) interventions have demonstrated actual reduction in marijuana use. Among untreated adolescents, marijuana use typically accelerates until age 20, with outpatient treatment only reducing or leveling the slope of increasing use. This program predated the development of the core client outcome measures. The goal by goal presentation of performance below indicates what will be available in the FY2002 Report and Plan.

2.5.2 Goal-by-Goal Presentation of Performance

Measure 1: Clients treated with all five models will have significantly reduced marijuana use.

Rationale: As indicated above, the previous research in this area finds that all five interventions should be effective but little evidence of their relative effectiveness exists. This study will provide that type of evidence. Thus documenting the effectiveness of each of these models in the literature is a valuable and appropriate measure for this program.

Data Source and Validity of Data: Data collection is accomplished with standard instruments with known reliability and validity. These instruments have been administered to the clients by interviewers who have been trained to ensure consistency and validity.

Baseline: FY 1999, the odds of lifetime users having one or more symptoms of marijuana dependence were six times higher for those who first used under the age of 15 than those who started after the age of 18.

Target: Across the board tested models will improve client outcomes such as the reduction in marijuana use.

Progress Update: 500 clients have agreed to participate and 90% have completed interviews at 3,6,9 and 12 months.

2.6 Program Title: Starting Early, Starting Smart (SESS) (Cross cut: CSAP, CMHS and CSAT) (Interim Report) : Performance Measures

Performance Goals *Goal 3: Bridge the gap between knowledge and practice*	*Targets*	*Actual Performance*	*Reference*
1. All members of families who are identified as substance abusers will be offered treatment	FY 01: 100% FY 00: Not applicable FY 99: Not applicable	FY 01: TBR 8/01 FY 00: Not applicable FY 99 Baseline: TBR 8/00	**B97**
2. 50% of those family members provided substance abuse treatment will have reduced substance use at one year follow-up	FY 01: 50% FY 00: Not applicable FY 99: Not applicable	FY 00: TBR 8/01 FY 99: Not applicable FY 98 Baseline: TBR 8/00	B97
Total Funding:	**1997: $2,061,00** **1998: $2,576,00** **1999: $2,662,00** **2000: 0** **2001 Req: 0**		

Process Measures*

Performance Goals *Goal 3: Bridge the gap between knowledge and practice*	*Targets*	*Actual Performance*	*Refer-enc e*
1. Number of Grantee	FY 01:13 FY 00: 13 FY 99:Not applicable	FY 01: 13 or 100% of Target FY 00: 13 or 100% of Target FY 99: N.A.	**B97**
2. Number of Funded Grantees that			
(a) Developed Protocols on schedule	FY 01: 13 FY 00: 13 FY 99:Not applicable	FY 01: 13 or 100% of Target FY 00: 13 or 100% of Target FY 99: N.A.	
(b) Began data collection on schedule	FY 01:13 FY 00:13 FY 99:Not applicable	FY 01: 13 or 100% of target FY 00: 13 or 100% of target FY 99: N.A.	
(c) Ended Data Collection on schedule Will not occur until 3 years into project	FY 01: 13 FY 00: Not applicable FY 99: Not applicable	FY 01:TBR 8/01 FY 00: Not applicable FY 99: N.A.	
(d) Began Preliminary Data Analysis on schedule	FY 01:13 FY 00: 13 FY 99:Not applicable	FY 01: 13 or 100% of target FY 00: 13 or 100% of target FY 99: N.A.	
(e) Completed Analysis on schedule This should not occur until completion of data collection	FY 01: 13 FY 00: Not Applicable FY 99 Not applicable	FY 01:TBR 8/00 FY 00: Not applicable FY 99: N.A.	
(f) Submitted Final Report on schedule	FY 01: 13 FY 00: Not Applicable FY 99 Not applicable	FY 01:TBR 8/00 FY 00: Not applicable FY 99: N.A.	

* Process measures were not included in previous submissions.

2.6.1 Program Description, Context, and Summary of Performance

The goal of the program is to develop and test a comprehensive approach for at-risk families and children. This program is a cross center activity between the Center for Substance Abuse Prevention (CSAP) and the Center for Substance Abuse treatment (CSAT). CSAP is the lead on this project. Starting Early, Starting Smart, a SAMHSA-wide program, is developing and

testing an integrated mental health and substance abuse prevention and treatment services (behavioral health services), for children ages birth to seven years and their families/care givers, within primary health care service settings or early childhood service settings. As with the other projects in the KDA portfolio this project has both process and performance measures.

Program Performance and Preliminary Data: In FY 1999 100% of the Federal and private partners have executed MOUs specifying their mutual expectations. FY 1997 baseline data on physical health, behavior, social and emotional functioning and language development have been collected and analyzed. Interim data are as follows: Physical Health--Asthma was the most commonly reported physical health diagnosis (180 of 1120 youth). Very few other chronic medical problems were reported (less than 4% of the sample reported any specific diagnosed problem). Overall, just under half (42.9 percent) of care givers rated their child's health as excellent, and approximately half of the care givers reported their child's health to be very good or good. Language---Clinical Evaluation of Language Fundamentals is the instrument which presents children with stories followed by comprehension questions and sentence recall. Children gave correct responses slightly more frequently than incorrect responses on both the Linguistic Concepts and Recalling Sentences in Context subscales. Social Skills---The rating scale for the PKBS indicates the frequency with which a child engages in particular behaviors. Care giver and teacher mean ratings of the target child's social skills were similar, with all subscale scores indicating that positive social behaviors were engaged in between "Sometimes" and "Often." Care givers tended to rate their child as having more frequent problems behaviors than did the teacher.

2.6.2 Goal-by-Goal Presentation of Performance

Measure 1:All members of families who are identified as substance abusers will be offered treatment.

Rationale: One of the critical risk factors for later substance abuse in children is substance abuse in the family. The first step on the road to recovery is access to treatment or prevention services for all family members. Treatment resources must be provided before access can be measured.

Data Source and Validity of Data: Data will be collected on referrals using a standard instrument to ensure validity and reliability.

Baseline: FY 1999, per the CSAP description, baseline data collection should begin shortly.

Target: 100% of members of families who are identified as substance abusers will be offered treatment.

Progress Update: Some baseline data should be available for next year's report.

Measure 2: 50% of those family members provided substance abuse treatment will have reduced substance use at one year follow-up.

Rationale: Experience with a range of substance abuse treatment strategies and review of the substance abuse treatment literature suggests that for 50%of those treated, having reduced substance use is a reasonable target. As this is primarily a treatment and prevention program for substance abuse, having reduced use at 1 years is an appropriate measure as indicated by the substance abuse treatment literature.

Data Source and Validity of Data: Data collection is accomplished with standard instruments of known reliability and validity. These instruments have been administered to the clients by interviewers who have been trained to ensure consistency and validity.

Baseline: FY 1999, until baseline service utilization data collection is completed in FY 1999, no information is available until November 2000.

Target: 50% of those treated will have reduced substance use at one year follow-up.

Progress Update: Follow-up data will not be available before FY 2002. During this time linkages and data infrastructure for data collection will be developed.

2.7 Program Title: Addiction Technology Transfer Centers ATTC (Interim Report)

Performance Goals *Goal 3: Bridge the gap between knowledge and practice*	*Targets*	*Actual Performance*	*Refer-ence*
1. Individuals trained/year	FY 01: 15,000 FY 00: 12,000 FY 99: 9,000	FY 01: TBR 8/02 FY 00: TBR 8/01 FY 99: TBR 8/00 FY 98: 6,300 FY 97: Baseline: 3,900	B97
2. Develop and implement nationally recognized standards to educate and train professionals.	FY 01: 50 States adopt standards FY 00: 39 States FY 99: 14 States	FY 01: TBR 8/02 FY 00: TBR 8/01 FY 99: TBR 8/00 FY 98 Baseline: 0 States (See interim report in the narrative)	B97

Total Funding:	**1998: $7,545,000** **1999: $7,792,000** **2000: $7,792,000** **2001 Req: $7,792,000**		

Process Measures*

Performance Goals *Goal 3: Bridge the gap between knowledge and practice*	*Targets*	*Actual Performance*	*Refer-ence*
1. Number of Grantee	FY 01:14 FY 00:14 FY 99:14	FY 01: TBR FY 00: TBR FY 99: 14 or 100% of Target	**B97**
2. Number of Funded Grantees that (a) Developed Protocols on schedule	FY 01: 14 FY 00: 14 FY 99: 14	FY 01: TBR FY 00: TBR FY 99: 14 or 100% of Target	
(b) Began data collection on schedule	FY 01:14 FY 00:14 FY 99: 14	FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99: 7 or 50% of Target	
(c) Ended Data Collection on schedule; Will not occur until 3 years into project	FY 01: 14 FY 00: Not Applicable FY 99: Not Applicable	FY 01: TBR 8/01 FY 00: Not Applicable FY 99: Not Applicable	
(d) Began Preliminary Data Analysis on schedule	FY 01: 14 FY 00: 14 FY 99: 14	FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99: 7 or 50% of target	
(e) Completed Analysis on schedule This should not occur until completion of data collection	FY 01: 14 FY 00: Not Applicable FY 99: Not Applicable	FY 01: TBR 8/00 FY 00: Not Applicable FY 99: Not Applicable	
(f) Submitted Final Report on schedule	FY 01: 14 FY 00: Not Applicable FY 99: Not Applicable	FY 01: TBR 8/00 FY 00: Not Applicable FY 99: Not Applicable	

* Process measures were not included in previous submissions.

2.7.1 Program Description, Context, and Summary of Performance

The current goal of this program is to provide training to substance abuse treatment professionals using the best treatment strategies available. Created in FY 1993, the original Addiction Technology Transfer Centers (ATTCs) included 11 geographically dispersed grantees covering 24 States and Puerto Rico who received their final funding in FY 1997. The ATTCs are a critical component of CSAT's overall strategy for promoting the adoption of best practices in substance abuse treatment.

The ATTCs disseminate research-based knowledge on addiction through state-of-the-art education and training programs, using comprehensive educational packages/curricula addressing all elements of addiction treatment and recovery, for addictions treatment and public health/mental health personnel, institutional and community corrections professionals, and other related disciplines. These programs are presented in traditional format as well as through a variety of innovative distance technologies. Other models of dissemination through the ATTC program include the presentation of symposia/ workshops/papers at national, regional, and State professional meetings, exhibit booths, newsletters, Web sites, multi disciplinary and cross-disciplinary linkages, consortia development and technical assistance (SSAs, academic institutions, community-based and managed care organizations, professional associations, community organizations, etc.), and interagency collaboration. CSAT is actively engaged with National Association of Alcohol and Drug Abuse Counselors (NAADAC) and the International Certification and Reciprocity Consortium (ICRC) in developing national standards for substance abuse treatment professionals; ONDCP has also joined in the discussions in order to provide further impetus.

CSAT funded a new set of 14 grantees in September, 1998 to continue this important work using a more comprehensive and integrated approach. The ATTCs are working with national associations and contractors to develop a collaborative, tiered national credential for substance abuse counselors. In addition, the ATTCs are working within their individual catchment areas (covering 39 States) to upgrade the credentialing standards. The ultimate goal is to have all States accept the national credential under development.

2.7.2 Goal-by-Goal Presentation of Performance

Measure 1: After an initial start-up phase, maintain training at 12,000 individuals per year

Rationale: Since substance abuse treatment professionals trained in the best treatment strategies available should provide more effective treatment, improving the skills of substance abuse professionals should improve the overall effectiveness of treatment.

Data Source and Validity of Data: Data collection with standard instruments with known reliability and

validity have been administered to the clients by interviewers who have been trained to ensure consistency and validity.

Baseline: In FY 1997, no individuals received training from the ATTCS, as this is a new project with new ATTCs.

Target: The FY 1999 target is 9,000 individuals. In FY 2000, 12,000 individuals will be trained.

Progress Update: New activity.

Measure 2: Develop and implement nationally recognized standards for education and training for substance abuse treatment professionals (ONDCP Target 3.4.1)

Rationale: Adopting uniform standards based on best practices will assure that all clients have access to well trained, effective substance abuse professionals and thus is an appropriate measure for this project.

Data Source and Validity of Data: Data will be collected via steering committee group minutes and expert panels in addition standard instruments will be developed to address this issue in the projects evaluation.

Baseline: No States.

Target: 39 States will have adopted standards by FY 2000; all 50 States will adopt standards by 2001.

Progress Update: Standards have been developed by the ATTC. Grantees are in the process of developing a plan for the standards to be disseminated. Once dissemination has occurred and once a sufficient amount of time has elapsed a method of measuring the adoption will be developed, which is in line with diffusion theory.

Substance Abuse Prevention

The mission of the Center for Substance Abuse Prevention is to decrease substance use and abuse and related problems among the American public by bridging the gap between research and practice. To this end CSAP (1) develops prevention policies and systems based on scientifically defensible principles that can be adapted to meet the specific needs of states and communities; and (2) develops and disseminates knowledge about approaches that improve the effectiveness of preventive interventions in such settings as schools, health care facilities and work sites. Effective substance abuse prevention addresses all age groups and populations, but youth are particularly vulnerable, and the majority of CSAP's activities focus on educating and enabling America's youth to reject illegal drugs as well as alcohol and tobacco.

According to 1998 NHSDA results, adolescent substance use, in particular among younger adolescents, has increased in the United States since 1991 despite 12 years of success in the 1980's reducing youth drug use from its all time high in 1979. The prevalence of marijuana use among youth more than doubled from 1992 to 1998. Current alcohol use by youth under 21 remains high at 10.5 million. Of this group, 5.1 million engage in binge drinking. In 1998, an estimated 18.2 percent of youth ages 12-17, or 4.1 million, were current cigarette smokers. In addition, demographics point to a surge in the youth population -- the 12-20 year old group will increase by 21% in the next fifteen years. This translates into an additional 6.75 million youth needing age- and culturally-appropriate substance abuse prevention services.

There is strong evidence that substance abuse is preventable and prevention is cost-effective. The following are just a few highlights of our programs successes:

< The results of the community partnership evaluation demonstrated lower substance use rates for particular populations in CSAP partnership communities vs. comparison communities. Of particular interest for future programs, is that there are significant differences by gender.

< Preliminary results from the Predictor Variable Study demonstrate that age appropriate interventions are successful when they target particular risk factors (e.g. parenting behavior,

family cohesion, aggressive behavior and social competency associate with each developmental level.)

< Requests from The National Clearinghouse on Alcohol and Drug Information (NCADI) have been significantly increased by the ONDCP national youth anti-drug campaign. For example, after the first two weeks of the campaign, NCADI had a 121% increase in caller volume.

< GirlPower, part of the Secretary's Youth Substance Abuse Prevention Initiative (YSAPI) so far has stimulated : 1,041 articles in print media; news coverage on major network, cable and local stations; reached over 15.5 million people via radio, and stimulated 3.2 million website visits since the campaign launch.

The following programs will be reported in the GPRA plan:

Goal 1: Assure services availability
2.8 Prevention Set-aside from SAPT Block Grant
2.9 Synar Amendment

Goal 2: Meet emerging and unmet needs
2.10 State Incentive Grants /YSAPI
2.11 Community Coalition

Goal 3: Bridge the gap between knowledge and practice
2.12 Predictor Variables
2.13 Starting Early/Starting Smart
2.14 Youth Connect
2.15 Workplace Managed Care
2.16 NCADI
2.17 Media Campaigns/YSAPI
2.18 Centers for the Application of Prevention Technologies/YSAPI

A full listing of CSAP programs and activities are contained in the following table:

Activity Table - Center for Substance Abuse Prevention

*An asterisk indicates that performance information is reported in the FY 2001 performance plan and report. Activities not asterisked are time-limited activities that will be reported out approximately one year following their completion. These activities are measured in a manner similar to other activities within their goal area.

	First Funded	Completed	First Reported
Goal 1: Assure services availability			
CSAP 20% Percent SAPT Block Grant Prevention Set-Aside		Ongoing	FY 1999*
CSAP Synar Amendment Implementation	FY 1997	Ongoing	FY 1999*
Goal 2: Meet emerging and unmet needs			
State Incentive Grants (component of YSAPI)	FY 1997	Ongoing	FY 2000*
CSAP Community Coalitions Program	FY 1994	FY 2000	FY 1999*
Goal 3: Bridge the gap between knowledge and practice			
Prevention Intervention Studies on Predictor Variable by Developmental	FY 1996	FY2001	FY 1999*
Stages Starting Early/ Starting Smart: Early childhood Collaboration Project	FY 1997	FY2000	FY 2000*
Youth Connect-High Risk Youth Mentoring/Advocacy Program	FY 1998	FY2001	FY 2001*
Workplace Managed Care	FY 1997	FY2000	FY 2000*
Initiatives on Welfare Reform and Substance Abuse Prevention for Parenting (Short title: Parenting Adolescents)	FY 1998	FY2000	FY 2001
Children of Substance Abusing Parents (COSAP)	FY 1998	FY 2000	FY 2001
CSAP Clearinghouse Program		Ongoing	FY 1999*
National Public Education Efforts (linked to YSAPI)	FY 1997	Ongoing	FY 2000*
Centers for the Application of Prevention Technologies (CAPT)	FY 1997	Ongoing	FY 2000*
Faculty Development Program	FY 1998	FY 2000	FY2001
Expected:			
Family Strengthening	FY 1999	FY 2002	FY 2003
Community-Initiated	FY 1999	FY 2001	FY 2003

2.8 Program Title: 20% Substance Abuse Prevention and Treatment Block Grant Prevention Set-Aside Annual Report of Ongoing Activity

Performance Goals *Goal 1: Assure services availability*	*Targets*	*Actual Performance*	*Refer-ence*
1 Increase number of States that incorporate needs assessment data into block grant application (Was Measure 3 in the FY 1999 plan; revised in FY 2000 to show incorporation of needs assessment data into block grant application rather than simply conducting the assessment; revised in FY 2001 to show number rather than percentage. Note: FY 99 Measures 2 and 4 were dropped in the FY 2000/Revised FY 1999 Plan).	FY 01: 38 States FY 00: 34 States FY 99: 27 States	FY 01: TBR 6/01 FY 00: TBR 6/00 FY 99: 26 States FY 94 Baseline (reported in FY 96 application): 13 States	B93
2 Increase % of States that use funds in each of 6 prevention strategy areas (Was Measure 1 in FY 1999 plan).	FY 01: 100% FY 00: 90% FY 99: 80%	FY 01: TBR 6/01 FY 00: TBR 6/00 FY 99: 90% of States (52 of 58 available from SAPT applications) FY 96: Baseline: 34 States (56%)	B93

3 Increase satisfaction with technical assistance. (Was Measure 5 in FY 1999 plan).	FY 01: 90% with 80% response rate; increase "outstanding" rating to 40% FY 00: 90% with 60% response rate FY 99: 90% with 60% response rate	FY 01: TBR 6/01 FY 00: TBR 6/00 FY 99: 94% satisfactory rating with 100% response rate FY 97 Baseline: 90% satisfactory rating, with 60% responding; 25% outstanding rating	B93

4. Identify and complete testing of prevention performance outcome measures			B93
4a: Increase to 21 States the number of States using MDSI process measures;	FY 01: 21 States use MDSI process measures; FY 00:5 outcome measures tested in 11 states FY 99: N.A.	FY 01: TBR 6/02 FY 00: TBR 6/01 FY 99: 20 States using MDSI process measures FY 97: Baseline: 11 States using MDSI	
4b. Increase States reporting block grant voluntary outcome measures.	FY 01:15 states reporting outcomes FY 00: 10 states reporting outcomes FY 99: N.A.	FY 01: TBR 6/02 FY 00: TBR 6/01 FY 99: 4b. SIG 6 states testing multiple outcome measures at the State, local and program levels; 5 outcome measures included as voluntary SAPT block grant measures FY 97: Baseline: 0 States reporting outcomes in the SAPT application	
4c. Identify 5 potential prevention performance outcome measures through the minimum data set activity and complete testing in at least 11 States. Modified in FY 2001plan. MDSII activities identifying and testing outcome measures transferred for next stages to SIG State program for piloting. (Was Measure 6 in FY 99 plan)	FY 01: 11 states tested FY 00: 5 states tested FY 99: N.A.; target first set in FY 2000.	FY 01: TBR 6/02 FY 00: TBR 6/01 FY 99: Baseline: 0 states	
Total Funding:	**1997: $248,920,000** **1998: $248,920,000** **1999: $301,150,000** **2000 : $304,850,000** **2001 Req: $309,890,000**		

2.8.1 Program Description, Context, and Summary of Performance

The goals of this program are to assist States and communities (1) to expand and enhance the availability, delivery, and quality of substance abuse prevention services and 2) to enhance State flexibility to target funds to local substance abuse priorities. Prevention services are advanced by improving, monitoring, and complying with the Substance Abuse Prevention and Treatment (SAPT) Block Grant requirements, and testing outcome measures associated with reducing alcohol and drug abuse. The importance of this program is particularly evident given the alarming trend of first time drug users across several categories cited in the Summary of Findings from the 1998 National Household Survey on Drug Abuse. For example, in 1997 an estimated 2.1 million persons first used marijuana, translating to about 5,800 new marijuana users per day. Also in 1997, an estimated 81,000 persons used heroin for the first time, 730,000 persons became cocaine users, and an estimated 2.1 million people began smoking cigarettes daily. Given the overwhelming indications of these statistics, it is imperative that prevention service providers gain better precision in securing accurate numbers of individuals served, a continuing challenge for States. Efforts are underway to strengthen State data collection capabilities and measures will be in place within the next 2 years.

States vary widely in the extensiveness and scope of their prevention services due to the varying degree of State contributed funding. That is, States that are able to commit State prevention funds are better prepared to base program decisions on a statewide planning process, adopt research-based programs to address unmet needs, and collect outcome data to evaluate the effectiveness of program efforts. While some States depend entirely on the 20% set-aside to support prevention programs and activities, others are able to expand their scope to fill major gaps in program services through the use of State funds

The Analysis of State Alcohol and Drug Abuse Data Report (State Resources and Services Related to Alcohol and Other Drug Problems for Fiscal Years 1996 and 1997; July, 1999) found the SAPT Block Grant to be the primary source of funding for 22 States in FY 96 and the preceding 3 years. This trend indicates that CSAP must continue to strengthen efforts to provide States with policy and program guidance for use of the 20 percent prevention set-aside. Through the Technical Assistance to the States Program, CSAP provides States guidance on a wide range of topics including but not limited to: comprehensive State prevention systems; State infrastructures; ensuring program quality; and compliance with Block Grant regulations.

One of the most significant impacts of CSAP's efforts is to generate synergistic effects of bringing States together around common problems with solutions specific to their own special conditions. Another special feature of this synergistic approach is to raise the level of functioning and effectiveness of States which are less advanced than others. As an example, several States convened to jointly develop and refine an orientation process for new state prevention staff. Similarly, needs assessment contract states have worked together to reach consensus on common instruments for student and

community resource assessment studies. States have been receptive to this process that promotes on-going collaboration and mentorship. Standard measures are applied to these activities where possible.

It is important to recognize that there are few prevention requirements imposed by the SAPT block grant legislation and therefore CSAP has little direct control over the intermediate and long term outcomes. As States move toward consensus regarding common use and reporting of outcome data, CSAP will transition toward performance measures that will reflect those agreements. The recent reauthorization bill for SAMHSA that was passed by the Senate would hold States more accountable for how they use Federal funds as a performance partnership block grant.

Long Term Indicators of Success for the Block Grant Program in supporting SAMHSA goal 1: assure service availability:

< In FY 1999, 26 States included needs assessment data in their block grant applications, representing a 100% increase over the FY 1994 baseline.

< 90% of States, used prevention funds in each of the six prevention strategy areas, representing an increase of 34% over the FY96 baseline.

< 94% of states responding reported satisfaction with the technical assistance received, an increase of 4% over the FY97 baseline.

< 20 States are now collecting common process data using the MDSI 5 voluntary outcome measures which is 9 more than in 1997. These and other measures are being tested by the SIGs and other States.

2.8.2 Goal-by-Goal Presentation of Performance

Performance Goals: Goal 1- Assure Service Availability. Performance measures emphasize service outcomes and the utilization of quality tools such as needs assessment and data infrastructure development.

Measure 1: Increase the number of States that will incorporate needs/ resource assessment data into intended use plan in the block grant application

Rationale: Scientific findings from State needs assessment studies must be operationalized into resource allocation and strategy selection choices. This is not only important from the point of accountability but is an indicator of continuing quality improvement in services and their impacts.

Data Source and Validity of Data: SAPT Block Grant application. It is important to note that data reported is for approximately two years prior to the block grant submission. For example, 1996 data

would be reported in the 1998 application. The validity of the information within the SAPT block grant application is the responsibility of the State. State Project Officers are in regular contact with their States.

Baseline: FY 1994: Thirteen states.

Target: FY 2000 target 34; FY 2001 target 38

Progress Update: In 1999, 26 States incorporated their data into their plans, representing a 100% increase over the baseline and falling just one State short of the target. Because of this significant progress, CSAP still fully expects to be able to meet its FY2000 target. States are using their needs assessment data to improve access and target resources to where they are most needed for particular populations. For example:

- as a result of the CSAP-funded middle school survey, the New Jersey state governor launched the "systematic drug abuse initiative: peers leading peers in the war against drugs" with inclusion of 50 middle schools each year.
- in Texas, information from CSAP's needs assessment support is being used to justify program services for under served populations, specifically targeted to Hispanics and college students.
- Utah's Department of Education used the prevention needs assessment data for allocating Drug-Free School funds.

Of the 27 states with needs assessment contracts, 26 of 27 states reported the following:

State funds invested for prevention needs assessment in most recent fiscal year(s)

	Number of states
$10,000-$20,000	1
$20,000-$50,000	2
over $50,000 ($100,000-$400,000)	12
none/unknown	11*

*(primarily cohort iii and iv states in the early/middle stages of their prevention needs Assessment contract)

Purpose for current state prevention needs assessment data

	Number of states
prevention planning	25
resource allocation	22
substate program grants	19
performance/outcome measurement	16
other	10

Types of prevention needs assessment data currently used by the states

	Number of states
risk and protective factor data	26
incidence and prevalence data	25
resources and services data	18
other	4

Sample state key findings may be found in Appendix: B.4.

Measure 2: Increase the percentage of States and Territories that will apply block grant funds to activities in all of the six prevention strategy areas.

Rationale: Substance abuse prevention research literature strongly suggests that just as there are numerous causes of substance abuse, there are numerous strategies for prevention. In order to be effective, prevention activities have to be multifaceted, repetitive and increasing in dosage. Based upon this research, Federal and State representatives designed a conceptual framework composed of six prevention strategies: information dissemination, education, alternative activities, problem identification and referral, community mobilization and environmental activities. States are required to distribute block grant-funded prevention activities in each of the legislatively mandated six strategy areas. These measures are important indicators of the progress being made by the States to develop a comprehensive prevention system that addresses the prevention needs of all population groups. In addition, through these six prevention strategies, materials that are developed in other CSAP KD, KA and TCE programs are disseminated, applied, and replicated.

Data Source and Validity of Data: Block grant application. The validity of the information within the SAPT block grant application is the responsibility of the State. Project officers are in regular contact with their assigned States.

Baseline: In FY 1996, 34 States (56%) were applying block grant funds to activities in all of the six prevention strategies.

Target: FY 2000 target 90%; FY 2001 target 100%.

Progress Update: CSAP has been working closely with the States and with the National Association of State Alcohol and Substance Abuse Directors (NASADAD) to develop a State Profiling System of block grant monies allocated to the six prevention strategies. In 1999, of 52 states and territories, 90% applied block grant funds to all six strategies, thus exceeding the target.

Measure 3: Increase satisfaction with technical assistance. (FY 2001: Maintain at 90% (with an 80% response rate) the number of States that will provide a satisfactory rating, and

increase to 40% the number of States that will provide an outstanding rating, of TA services received within the prior two years.

Rationale: Technical assistance that is appropriately designed, marketed, and targeted will meet State needs and will serve to enhance local prevention efforts. To varying degrees, States need assistance in putting to effective use available science-based reports, studies, and analyses. Most of such literature is written by researchers for researchers and exists in locations/sources that are unfamiliar or not easily accessible. There is a great need for such materials to be translated, transformed into educational materials which are user-friendly, and disseminated effectively.

Data Source and Validity of Data: The Prevention Technical Assistance and Training to the States (PTATS) Customer Satisfaction survey. Face validity would appear strong given the directness and simplicity of the questions (e.g. were you satisfied with the technical assistance you received?)

Baseline: FY 2000: 90% with 60% response rate. FY 1999: 90% with 60% response rate.) 90% satisfactory rating and 25% outstanding rating, (with 60% responding).

Target: FY 2000: 90% with 60% response rate.

Progress Update: In FY 1999, 94% of those responding found the technical assistance provided to be satisfactory.

Measure 4: In FY 2001, (a) increase to twenty one (an additional ten States) the number of States using MDS I process measures and(b) increase the number of States participating in the SAPT block grant voluntary outcome measure reporting activity to 15 (c) increase to eleven, the number of pilot states who complete outcome measures testing

Rationale: The identification of performance measures for mental health and substance abuse has been identified as a critical need. (A) A number of States, through MDS I have identified and are collecting process data that describe the numbers and types of populations being served and services being supported by block grant funds. In 1997, twenty-seven states convened to discuss extending that activity to include collection of performance outcome measures (MDS II). That group used a number of criteria to identify potential priority indicators that merited further examination. Consideration of those recommendations, in conjunction with ONDCP and SAMHSA requirements led to follow-up activities impacting the SAPT application and the SIG program. The FY 2000 SAPT block grant revision now includes optional forms that States can use to voluntary report on five outcome measures for block grant funded programs. These measures were selected based on the MDSII activity, SIG core measures and CSAP mission measures. The FY 2000 block grant application revision has recently received OMB approval, so States can now begin to report on the effectiveness of their programs (measure 4b). Additionally, the SIG states have volunteered to pilot a number of outcome measures, including those proposed by the MDSII group (measure 4c).

Baseline: FY 1998: (a) Eleven States use MDS I process measures. (b) No states currently report outcome data in the SAPT application, (c) No SIG states reporting outcome data.

Target: See table for a listing of targets for 4a - 4c.

Data Source and Validity of Data: States' information systems and surveys of states. SAPT block grant application. Validity of MDS I measures being assessed. Outcome measures use scales of widely used, validated standardized instruments such as NHSDA, MTF, and the Seven State Survey. These are consistent with the SAMHSA GPRA core client tool.

Progress Update: Measure 4a: A Minimum Data Set (MDS) initiative, an electronic system to count service data, has been underway to assist States and CSAP in the development, implementation, and application of a State uniform performance monitoring and measurement system. Eleven States participated in the Phase I pilot of the program, which focuses on process measures and services data. A collaborative effort resulted in agreement on data items, definitions, methods of data collection, the development of a PC based software system, and technical assistance related to training and installation. As of July, 1999, twenty states are using or implementing MDSI. States can use the results to allocate resources and improve State planning for prevention programs. Depending on funding for infrastructure support, Phase I data can be provided to CSAP for analysis and aggregation at the national level, which will provide important information about the number and types of prevention services provided and populations served. More advanced Phase I software is being developed. Two examples of MDSI states include:

Colorado: Colorado has developed their MDSI system to collect demographic, program, and activity information on all of their service providers. The State has also developed a program evaluation system to monitor provider planning and implementation efforts. Using these two systems, Colorado now has the ability to plan, design, and develop program services and strategies that meet the prevention needs of the State.

Colorado determined that initial MDS reporting showed less services to ethnic/minority and under served populations than was assumed. Colorado reexamined their services to ethnic/ minority populations and the activities available to those groups based on that reported data. New programs/services were developed to serve these groups.

Pennsylvania: Pennsylvania has also developed their MDSI system to monitor local planning, programming, and service provision. Based on the MDSI data collection effort, Pennsylvania officials develop future program goals in terms of planning prevention activities, the clientele to be served and defining effective strategies.

Measure 4b: MDS II focused on intermediate and long term outcome measures. The FY 2000 SAPT block grant application has been revised to incorporate forms by which States can voluntarily report on five outcome measures for their block grant funded programs. This revised form reflects the work previously done under MDSII and other efforts. CSAP is working with interested States and NASADAD to develop and implement a collaborative process by which all interested parties can reach agreement and finalize SAPT block grant program priority outcome indicators, identify obstacles to State reporting, mechanisms for overcoming these barriers, and agree to reasonable time lines for national implementation of block grant outcome reporting.

Measure 4c:. The work of MDS II has influenced several other State activities related to outcome performance measurement. The work accomplished under MDSII has been carried forward and implemented by the SIG program. The SIG grantees have agreed to collect common State, local and program level outcome measures which include MDS II indicators. Data collection has already begun in SIG states.

2.9 Program Title: Synar Amendment (Section 1926) Implementation Activities Annual Report of Ongoing Activity

Performance Goals *Goal 1: Assure services availability*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase number of States whose retail sales violations is at or below 20% (Was Measure 3 in FY 1999 plan. 1999 Measure 1 was dropped in the FY 2000/Revised FY 1999 Plan.)	FY 01: 36 States (Was 30 states) FY 00: 26 States (Was 12 states) FY 99: 8 States (FY00 and FY01 revised upward)	FY 01: TBR 6/01 FY 00: TBR 6/00 FY 99: 21 States FY 98: 12 States FY 97 Baseline: 4 States	B69
2. Maintain periodic technical assistance for implementation of guidelines	FY 01: Maintain FY 00: Maintain FY 99: 100%	FY 01: TBR 6/01 FY 00: TBR 6/00 FY 99: 100% FY 97 Baseline: 12 States (20%)	B69
Total Funding:	**1997: $1,350,000** **1998: $1,400,000** **1999: $1,300,000** **2000: $1,500,000** **2001Req:$14,100,000**		

2.9.1 Program Description, Context, and Summary of Performance

The goal of this program is to reduce the sales rate of tobacco products to minors in all States. This program provides assistance to the States to enhance their ability to comply with Synar regulations in the SAPT block Grant. All States have established data collection and enforcement procedures to comply with Synar regulations, and many States are working (with supportive technical assistance) to improve their established procedures. Through the delivery of technical assistance, CSAP supports the States in reducing retail sales of tobacco to youth by providing guidance on State level policy making concerns, assisting States with the identification of retailers and the development of retail outlet lists. In addition, CSAP also provides guidance on improving collaboration between State and local authorities responsible for complying with the requirements of Synar. Coordination with CDC and FDA continues.

2.9.1 Goal-by-Goal Presentation of Performance

Performance Goals: Goal 1 - Assure Service Availability. Performance measures the outcome of violations rate and the availability of periodic technical assistance.

Measure 1: In FY 2001, a total of thirty-six States will be at or below a 20% retailer non-compliance rate.

Rationale: Analyses of compliance rates are performed each year based on data reported in the SAPT block grant applications. Research evidence indicates that only consistent and vigorous enforcement of State tobacco access laws will reduce the sales of tobacco products to minors to 20% or less, and that through rigorous enforcement, all States can achieve that goal by September 30, 2003. Without such rigorous enforcement, a State that was once compliant could lapse in later years into noncompliance. The estimates of the number of States expected to be at or below 20% retailer non-compliance by FY2003 reflect the recent decision by the Department granting SAMHSA the ability to renegotiate interim target rates in FY2000 with all of the States. Due to the success of this program, FY2000 and FY2001 targets were revised upward.

Data Source and Validity of Data: The data source is the Synar report which is a part of the SAPT block grant application submitted annually by each State. The validity and reliability of the data are expected to be high in view of the TA being provided, the number of random unannounced surveys being conducted, and the confirmation of the data by scientific experts, site visits and other similar steps.

Baseline: The FY 1997 baseline for States with violation rates at or below 20% was four

Target: FY 2000 increase to a total of 26 States; FY 2001, increase to 36 states.

70

Progress Update: In FY 1999, a total of twenty-one States (nine more than the 1998 total) achieved a sales rate of tobacco products to minors of 20% or less. SAMHSA surpassed its FY99 target, and therefore has revised FY 2000 and FY 2001 targets upward.

Measure 2: In FY 2001, maintain at 100% the proportion of States provided with periodic technical assistance in implementation of guidelines to meet Synar goals.

Rationale: CSAP is in a unique position to provide leadership and guidance to States on overcoming barriers to developing appropriate sample designs and other technical materials, based on scientific literature and demonstrated best practices, for the effective implementation of Synar. The FY 2000 measure of 100% will be maintained.

Data Source and Validity of Data: The data sources for the baseline and measures were derived from State project officers' logs and organizations who were awarded State TA contracts. The analysis will be based upon the actual requests/responses received, therefore providing a high degree of reliability and validity.

Baseline: In FY 1997 twelve States received technical assistance in implementing the guidelines to meet the Synar goals.

Target: FY 2000 and 2001, maintain at 100% of states.

Progress Update: In FY 1999, SAMHSA achieved its FY99 target. All of the States were provided periodic technical assistance in the implementation of guidelines to meet Synar goals. Technical assistance activities included working with States to strengthen their current youth tobacco control programs by assisting in the development of lists of tobacco retailers, in the identification of outlets within the State, and assisting States in identifying additional interventions toward reducing retail sales to minors. Technical assistance has also been provided to assist States reduce retail sales by assisting with the development and strengthening of merchant education programs, the provision of information on technological interventions available for limiting sales (e.g. ID card readers), guidance on developing community mobilization programs, and assistance with improving collaboration between State and local authorities responsible for complying with the requirements of Synar. In addition, multi-State technical assistance events were held, including the following:

1. Fourth National Synar Workshop (March 1999)
2. Synar Four-State Orientation Workshop (January 1999)
3. Synar State-to-State Conference Calls (November 1998 - February 1999)
4. Tools and Skills to Build Collaboration on Synar Workshop (October 1998)

2.10 Program Title: State Incentive Grants SIGs (A component of YSAPI)

Performance Goals Goal 2: Meet emerging and unmet needs	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase State collaboration rating in the following areas: (a) prevention service delivery (b) prevention legislation/policies (c) use of prevention related resources	FY 01: TBD 9/00 FY 00: 25% increase in collaboration for (a), (b) & (c) FY 99: N.A. New in FY 2000	FY 01: TBD 9/02 FY 00: TBR 9/01 FY 99: Baseline (from FY 98 data) (a) 56% (b) 28% (c) 15%	B69
2. Decrease past month substance use for youth 12-17 (YSAPI measure)	FY 01: TBD 9/01 FY 00: 15% decrease from FY 98 baseline FY 99: N.A.	FY 01: TBR 8/02 FY 00: TBR 8/01 FY 99: TBR 8/00 FY 98 Baseline: 1998 NHSDA data - 9.9%	B69
3.Maintain the number of science-based programs being implemented by local sub-recipients in SIG states (new measure)	FY 01: At least 50% of all SIG-funded sub-recipient programs will be science-based FY 00: (N.A.; New measure in FY01) FY 99: N/A New Measure in FY 01	FY 01: TBR 9/01 FY 00: TBR 9/00 FY 99: N/A (new measure)	
Total Funding:	**1997: $15,000,000** **1998: $55,993,000** **1999: $61,652,000** **2000: $61,652,000** **2001 Req: $87,000,000**		

2.10.1 Program Description, Context, and Summary of Performance

The 1995 National Household Survey on Drug Abuse showed some disturbing increases in drug use among youth, particularly in marijuana use. To get at the underlying causes of this complex problem, HHS Secretary Donna E. Shalala reviewed the current state of the art in prevention services nationwide. The Department's findings showed an inadequate system to support prevention efforts at

the national, State and local levels. In particular, prevention was characterized by a lack of comprehensive national and State prevention strategies that resulted in the following:

1. Uncoordinated and fragmented use of resources, knowledge and information relating to what works in prevention;

2. A lack of systematic evaluation of programs and practices to identify effective, scientifically derived approaches; and

3. A lack of a systematic approach for disseminating these research findings to prevention program providers.

In response to these problems, Secretary Shalala initiated the Youth Substance Abuse Prevention Initiative (YSAPI) with the goal of significantly reducing substance use among youth in communities nationwide. The SIG program has become a cornerstone of YSAPI, promoting effective coordination and collaboration at the State level to implement science based strategies at the community level targeted towards reducing youth substance use. The goal of the SIGs program is to assist States and communities expand and enhance the availability, delivery, and quality of substance abuse prevention services nationally, while enhancing State flexibility to target funds to local substance abuse priorities by a) improving, monitoring, and complying with Block Grant requirements, and b) testing outcome measures associated with reducing alcohol and drug abuse. Five states received awards in Cohort I, and an additional 14 comprise Cohort II. One additional state and the District of Columbia were added to Cohort II in FY 1999.

The SIGs show several linkages to the KDA programs. In particular: the bulk of the SIG funds must be devoted to actual prevention programming, and 50 percent or more of the programs must involve science-based programs. Science based is defined as "...identified and/or substantiated through an expert consensus or analytic process using commonly agreed upon criteria for rating research endeavors."(Science-based Practices in Substance Abuse Prevention: A Guide, December, 1998) Using common criteria, prevention programs were assessed and categorized (types 1-5) based on levels of support according to those criteria. Those programs categorized as types 3-5 were deemed science-based for the SIG program. To date, only the first cohort of five SIGs has selected its community prevention programs. Early indications are that each SIG State has an average of 60 prevention programs with 52 percent being at a rigorous, science-based level. It is important to note that, to allow room for innovation, all programs funded at the subrecipient level are not required to meet those rigorous criteria. Prevention programs are multi-faceted and therefore may fall under more than one of the identified domains (youth, family, community, school). Preliminary indications show that SIG programs gave highest priority to the youth domain, followed, respectively, by the family, community, and school domains.

States have agreed on the use of core indicators and measures to be collected across sites at the State, local and program levels (See Appendix B.3 for tables of indicators and measures). From these core measures, SIG States are also field testing several for their feasibility and usefulness in Block Grant application reporting. The SIG core measures reflect the logic model upon which the evaluation framework is based. That is, the framework represents assumptions and causal expectations about how SIG program activities reflect eleven categories within which the SIG program anticipates positive change: (1) SIG mobilization; (2) State-level system characteristics/dynamics; (3) sub-recipient characteristics/dynamics; (4) State-level collaborative strategies/activities; (5) sub-recipient planning/science-based prevention interventions; (6) State-level immediate outcomes; (7) sub-recipient immediate local outcomes; (8) State-level systems change; (9) intermediate outcomes (risk and protective factors); (10) Long-Term outcomes (behavioral impacts); (11) contextual conditions (economic, cultural). For example:

Long-Term State level outcomes: Substance use (10)

Constructs	**Indicators**	**Data sources**	**Instruments/measures**
Alcohol use	Lifetime, annual, monthly use; age of first use	Youth survey	Seven-state consortium survey Youth risk behavior survey Household survey
Tobacco use (cigarettes)	Binge drinking	Youth survey	Seven state consortium survey Youth risk behavior survey
	Lifetime, annual, monthly use; age of first use	Youth survey	Seven state consortium survey Youth risk behavior survey Household survey
Marijuana use	Lifetime, annual, monthly use; age of first use	Youth survey	Seven state consortium survey Youth risk behavior survey Household survey
Other illicit drugs	Lifetime, annual, monthly use; age of first use	Youth survey	Seven-state consortium survey Youth risk behavior survey Household survey

The bottom line impact of interest for the SIG projects is the reduction of alcohol, tobacco and illicit drug use in the target populations of the local sub-recipient communities. In general, measures of actual use of each of the substances listed above included four primary indicators: lifetime use, annual use, 30-day use, and age of first use. Finally, the importance of evaluation in this far-reaching CSAP initiative has been abundantly emphasized at all levels. SIG grantees have responded to this with their own detailed plans and willingness to compromise on behalf of the national agenda.

2.10.2 Goal-by-Goal Presentation of Performance

Measure 1: Increase State level collaboration rating from the 1998 baseline

Rationale: The States receiving SIGs are developing new substance abuse prevention systems through collaboration with other State agencies and the combining and leveraging of resources and dollars. Over the 3 years of funding, each State will document and evaluate this new prevention system and do qualitative comparisons with the "old prevention system. Collaboration will be rated using a survey being developed jointly by the initial cohort of SIG grantee states. Data will be aggregated by CSAP through a central data coordinating system and cross site comparisons will be conducted.

Data Source and Validity of Data: States have agreed on the use of the same instruments and types of data to be collected. Data will be collected through several mechanisms: State grantees, local (local community or provider project level) and through school and community-based surveys. Data are being sent to a CSAP data retrieval system for entry and documentation.

Baseline: SIG States have completed their instrument development and have collected the data . Cross-site analysis has determined the average level of collaboration across the program as follows:
(a) prevention service delivery -- 56%
(b) prevention legislation policies -- 28%
(c) use of prevention related resources --15%

Target: Annual collaboration targets are set with each new cohort, therefore, the next target will be determined in September, 2000.

Progress Update: SIG States, particularly Cohort 1, have implemented a number of collaboration initiatives as a direct result of their SIG cooperative agreement with CSAP. The continued development of the Cooperative Agreement Advisory Committee chaired by the Governor's representative has strengthened State level collaboration in all SIG States.

The SIG Program is achieving its goals through collaborations with the Governor's Office in each State. In particular, SIG States have been very successful in coordinating and leveraging prevention funding. Because the Governor is the recipient of the SIG grant, the SIG program structure allows States to identify gaps in prevention, optimize their statewide resources and develop strategies to implement needed programs and services. Governors have responded well to this opportunity and have put numerous innovations into practice.

Moreover, SIG States have been successful in identifying and leveraging prevention funds across their States. Preliminary indications show that some SIG States could potentially leverage up to 10 times the grant amount through matching funds. Governors have begun to leverage prevention resources in a variety of innovative ways.
Specific examples of collaborations and leveraging of funds include the following:

In Vermont, funds from United Way agencies, Safe and Drug Free Schools and other grants from State and local agencies and private businesses and foundations have been merged to support local prevention coalition activities. As a result of the SIG grant, for the first time, the Massachusetts Governor's Office mandated that all State agencies that fund substance abuse prevention meet regularly to coordinate their efforts and funding. The SIG program in Oregon has moved the State to work with every County to develop a single comprehensive plan incorporating substance abuse prevention with school success, juvenile justice, and teen pregnancy concerns. The State is also working with nine tribal governments for the first time in doing comprehensive substance abuse prevention. The SIG Program in Kentucky leveraged $650,000 in local funds to support science-based prevention activities. In Kansas the SIG prompted the Governor to issue an Executive Order establishing a Governor's Substance Abuse Prevention Council. This cabinet level group has already done a county-level resource assessment an developed a science based prevention publication that integrates guidelines and strategies across multiple federal and State funding sources. In Illinois and North Carolina the Governors have used the SIG opportunity as a vehicle for State agencies to focus on prevention domains and strengthen the connections between agencies to bring about new collaborations in prevention programming. The Colorado SIG has successfully pooled SIG and Drug Free School funds to provide more effective prevention services in community school districts.

Measure 2: In FY 2000, past month substance use will decrease by 15% among youth ages 12 -17 from the baseline (YSAPI measure)

Rationale: States will be measuring the reduction in youth substance abuse via State level measures, community level measures, and specific program measures to determine the effectiveness of science based prevention programs and the effectiveness of the new prevention system. The decrease in risk indicators will also be examined. These and other data will be aggregated by CSAP through a central data coordinating system and cross site comparisons will be conducted.

Data Source and Validity of Data: The NHSDA, a national survey with known and established reliability and validity, will be used, as well as individual State school surveys.

Baseline: FY 1998 9.9% (NHSDA survey results.) .

Target: 15% decrease from FY 1998 baseline

Progress Update: States have agreed to include the same items to measure this variable across State sites at all levels of analysis (State, community, program). This is a major forward step in moving towards State outcome performance measures. While the NHSDA can provide indirect State estimates (in most cases); the State surveys will be especially helpful by allowing analysis at lower levels (regional, local).

Measure 3: Maintain the number of science-based programs being implemented by local subrecipients in SIG States.

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Rationale: CSAP is the lead federal agency for substance abuse prevention and thus has a major role in identifying and disseminating knowledge to the field. CSAP is using the SIG Program to test practices, which have shown promise through past research, in a broad spectrum of current local conditions. As part of its mandate to States receiving SIG funds, States are required to use at least half of their SIG funding, after administrative costs, to implement science-based prevention programming at the local level. States are responsible for local evaluations of a sample of these programs. CSAP has assisted States in choosing local programs by developing a guide of science-based practices in substance abuse prevention that lists examples of science-based programs and explains the different levels of scientific integrity. This guide was developed by experts in the substance abuse prevention field and shared with the SIGs. (See overall SIG program narrative for more details in defining science-based programs).

In addition to the States' own evaluations of local programs, over the three years of their grants each State will report data from local subrecipients of SIG funds to CSAP on a semi-annual basis for the National cross-site evaluation.

Data Source and Validity of Data: A semi-annual grantee reporting system is the source of these data now and in the future. These data are self-reported by SIG subrecipients. A check on the validity of these data will be done though site visits to local programs by the cross-site evaluation team beginning in FY2000.

Baseline: FY1999 data to be reported in 9/00 (new measure).

Target: For FY 2001, at least 50% of all SIG funded sub-recipient programs will be science-based.

Progress Update: Thus far, three states have reported on their subrecipient data, which asks for the characteristics of their most important programs. (Many States have not yet had reached the point of identifying their local programs.)

2.11 Program Title: Community Coalitions Final Report of Evaluation of Completed Program

Performance Goals *Goal 2: Meet emerging and unmet needs*	*Targets*	*Actual Performance*	*Refer-ence*
Note: 1999 Measure 1 was dropped in the FY 2000/Revised FY 1999 plan. 1 Increase the mean number of organizations participating in activities (Was Measure 2 in FY 1999 plan).	FY 01: N.A. Program completed. FY 00: N.A. Program completed. FY 99: 40% increase	FY 01: N.A. Program completed. FY 00: N.A. Program completed. FY 99: 190 organizations (over 300% increase from baseline) FY 98: 186 organizations FY 97: 172 organizations FY 95 Baseline: Mean of 46 organizations	None
2 Increase prevention services that promote coalition efforts (Was Measure 3 in FY 1999 plan).	FY 01: N.A. Program completed. FY 00: N.A. Program completed. FY 99: 100% increase	FY 01: N.A. Program completed. FY 00: N.A. Program completed. FY 99: Target exceeded in FY 98. FY 98: 2297 FY 97: 1803 FY 95 Baseline: 595 programs coordinated, and implemented by 123 coalitions	None
Total Funding:	**1997: $36,171,000** **1998: $ 8,318,000** **1999: $ 6,422,000** **2000: $ 473,000** **2001 Req: Program Completed**		

2.11.1 Program Description, Context, and Summary of Performance

The goals of this program, which is now completed, were to increase community involvement in dealing with problems of substance abuse and its attendant effects, as well as to promote the development of infrastructure in communities for initiating and facilitating substance abuse prevention activities. This program focused on a community-wide approach to reducing substance abuse. The program was built on community-based theories of prevention, which address the community environment within which substance abuse occurs, not just the behavior of the individuals and families or those on the school campus.

Final analysis of the data collected as part of the national evaluation of the community partnership program is complete and efforts to disseminate the findings from the evaluation continue. Residential and school surveys, over two points in time, showed that:

24 representative partnership communities as a group were associated with lower rates of substance abuse, relative to 24 matched comparison communities as a group.

Only adults' alcohol use for the past month showed a statistically significant improvement in 12 measured outcomes. The measures addressed alcohol or illicit drug use for three age groups, adults, 10th graders, and 8th graders in the past month and for the past year.

For the partnership communities, male substance abuse rates were lower at the second point in time, relative to the comparison communities - usually by about three percent - on five out of the six outcomes: adult illicit drug use and alcohol use in the past month; 10th grade illicit drug use in the past month; and 8th grade illicit drug use and alcohol use in the past month (all comparisons were statistically significant).

When the responses for males and females were combined, only one of the six outcomes was significantly different, and favored the partnerships. The significant effects by gender has helped inform the community initiated study program which includes as a priority, studies using effective models for females.

When comparing individual partnerships with their paired comparison communities, 8 out of 24 partnerships showed statistically significant reductions in substance abuse. The surveys also revealed other statistically significant findings associating partnerships with the following outcomes:

Program Surveys also revealed less reports of adult illicit drug use in Community Partnership Programs.

Adults in partnership communities reflected being more involved in prevention activities; living in a "good" neighborhood (i.e., - a neighborhood free from drugs); and having a disapproving attitude toward drugs.

The study showed that gaining community involvement and recruiting and *involving* members in all aspects of community infrastructure building and prevention program implementation were significantly related to attaining the partnerships' stated prevention goals. The study also identified eight characteristics that were exhibited by those partnerships that had statistically significant reductions in substance abuse:

1. A comprehensive vision that covers all segments of the community and all aspects of community life;

2. Widely shared vision that reflects the consensus of diverse groups and citizens throughout the community;

3. A strong core of committed partners at the outset of the partnership;

4. An inclusive and broad-based membership with participation of groups from all parts of the community;

5. Avoidance or resolution of severe conflict that might reflect misunderstanding about a partnership's basic purpose;

6. Decentralized units within a partnership that encourage implementing prevention programs in small areas within a partnership and that empower residents to take action and make decisions;

7. Low staff turnover that, when it happens, is not disruptive; and

8. Extensive prevention activities and support for local prevention policies, reaching a large number of people for an extended period of time.

The success of this program has impacted the way other federal and state agencies do business. For example, Drug Free Schools and Communities (DFS/C) and Office of Juvenile Justice and Drug Prevention (OJJDP) programs are using CSAP results to help shape their community programs, and ONDCP has made increasing the number of community partnerships a performance objective for the nation. In addition, a number of states have incorporated working with communities into their prevention plans. CSAP itself builds on the knowledge gained through this program in designing the State Incentive and CAPTs programs among others.

The Community Coalitions Program (CCP) represents a continuation and expansion of a philosophy expressed in the Community Partnership Program. The effort is designed as an extension of the earlier community-based efforts to increase the breadth and reach of anti-drug partnerships through the joining together of, and collaboration of partnerships. A central tenet of the CCP is that interaction and linkages among partnerships will have a strong impact on policies and norms, bring about community-wide changes, and create stronger and healthier communities.

The national cross-site evaluation of the CCP employs a quasi-experimental design to assess changes in substance abuse and related health problems over the 1992-1998 period, using archival outcome indicator data. Archival outcome indicator data on substance abuse-related traffic fatalities, crimes, and hospital discharges have been collected for 85 coalition communities and their matched comparisons (170 communities) for the 1992-1997 period. Collection of 1998 data on these three sets of outcome indicators is continuing.

Data on traffic fatalities, crimes, and hospital discharges have been processed to calculate unadjusted and adjusted incidence rates to describe trends in substance abuse and related health outcomes over time. Coalitions program effects on reducing traffic fatalities, crimes, and hospital discharges were assessed for 85 pairs of coalitions and their matched comparisons over the 1992-1997 period through the use of a random-coefficients model. Of the six outcome indicators assessed, five were found in the hypothesized direction associated with lower incidence, (alcohol and drug use, alcohol-related arrests,

drug-related arrests, single-vehicle nighttime rashes, and illness, injuries, and diseases related to alcohol and drugs), but none were statistically significant.

Since prevention dosage, coalition building strategies, funding disruptions, number of former CSAP-funded partnerships, total number of partnerships, initial drug conditions, initial poverty conditions, and cohort were considered important in affecting coalition outcomes, the effects of these variables on substance abuse related traffic fatalities, crimes, and hospital discharges were investigated through eight subgroup random-coefficients analyses. An important cohort effect that was detected though the effects of the remaining seven variables was not statistically significant.

The coalitions building process was evaluated through the application of a structural equation model, utilizing the 1996, 1997, and 1998 data from the Coalitions Management Information Format and Framework Report. The analysis found a positive relationship between the coalition activities and actions and outcomes. Coalitions focusing on prevention activities and community actions were able to produce a positive impact on community risk and protective factors and ultimately led to reductions in substance abuse behaviors and related health outcomes.

Eight criteria were established to identify eight out of the 123 coalitions for the study of promising practices. These eight criteria were: evidence of success; comprehensive prevention strategies; presence of a Long-Term strategic plan with evidence of implementation; implementation of policy or legislative changes; stable governance and leadership; collaboration among member organizations; funding from multiple sources; and culturally sensitive approaches to prevention. Both processes and outcomes of the eight coalitions were assessed. The results indicated that the eight identified features were important in achieving coalition outcomes. The results of these analyses were reported in a draft report entitled “Promising Practices: Common Features of Exemplary Coalitions.”

2.11.2 Goal-by-Goal Presentation of Performance

Performance Goals: Goal 2-Meet emerging and unmet needs. Performance measures emphasize the extent to which the activity increases the number of participating organizations and increase prevention services.

Measure 1: Increase the Mean Number of Organizations Participating in Coalition Activities by 40 Percent

Rationale: Infrastructure development institutionalizes knowledge intended to be practiced through the community coalitions program, increasing the probability that its positive effects will last after the coalition is formed and its prevention programs are initiated. CSAP-supported community coalitions are required to have a minimum of two partnerships, and state-coordinated coalitions are required to have a minimum of three partnerships. A partnership is defined as a formally structured group of no fewer than seven (7) official member entities. During the first year of funding—FY 1995—the number

of partners in each coalition ranged from 2 to more than 50, with a mean of 6.3 partnerships in each coalition. As coalitions develop over the course of the grant period, both the number of community organizations and the number of partnerships participating in coalition activities is expected to increase.

Data Source and Validity of Data: CMIF which is a data source developed for the cross site evaluation. Information is verified via site visits, monitoring activities, and other reports.

Baseline: FY 1995 mean number of organizations per coalition participated in coalition activities equals 46.

Target: FY 2000 and 2001, not applicable, program completed.

Progress Update: Analysis of the process variables indicate that the coalitions have been involving an increasing number of organizations in the coalitions and have been increasing the extent to which they have adopted formal procedures such as having a governing board with elected officer and having formal operating procedures period. For example, the mean number of organizations participating in coalition activities has increased from the baseline (measure 1) of 46 in 1995, to 172 in 1997; an increase far exceeding the target of 40 percent. In 1998, the mean number of organizations participating in coalitions increased even more to 186, and 1999, to 190.

Measure 2: Increase Prevention Services That Promote the Coalitions's Substance Abuse Prevention Efforts by 100 Percent from the Base Year.

Rationale: In 1995, the coalitions were beginning to get organized. Over the course of the grant period, the coalitions completed assessments to identify needed prevention services, developed plans to meet those needs, and implemented the plans. This likely led to an increase in substance abuse prevention services. Rates were not expected to increase during the last year of the funding period due to the increased attention on evaluation activities during that period.

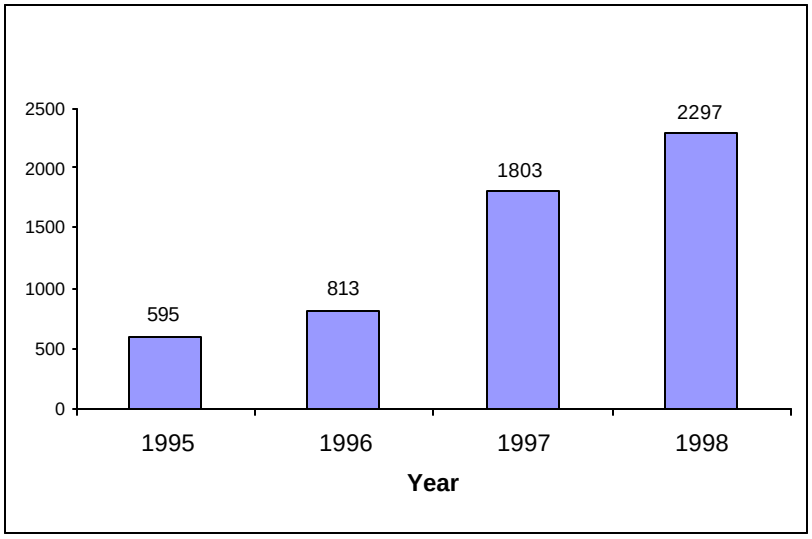
Data Source and Validity of Data: The Coalition Management Information Format (CMIF) is the source of the data. Information is verified via site visits, monitoring activities, and other reports

Baseline: FY 1995 595 prevention programs and services coordinated and implemented by 123 community coalitions.

Progress Update: As shown in Exhibit 1 below , the coalitions surpassed all expectations for measure 2. Specifically, FY 1997 data show that 1803 prevention programs and services were facilitated and newly created; an increase of approximately 300 percent (rather than the 100 percent targeted). 1998 data indicate that 2297 programs and services have been facilitated and/or created thus showing similar progress.

Exhibit 1

Number of prevention activities facilitated and newly created by coalitions (N=123)



Source: Coalition Management Information Format (CMIF).

2.12 Program Title: Prevention Intervention Studies on Predictor Variables by Developmental Stages Interim Report

Performance Goals: Goal 3: Bridge the gap between knowledge and practice	*Targets*	*Actual Performance*	*Reference*
Note: 1. Implement effective models (Was Measure 2 in FY 1999 plan; 1999 Measure 1 was dropped in the FY 2000/Revised FY 1999 Plan; Sites will be funded competitively for an additional year to permit additional data points. Accordingly, final reporting will be delayed by one year from that projected in the FY 2000 plan.)	FY 01: Not applicable; program completed FY 00: 8 sites FY 99: Not applicable; one-time report.	FY 01: Not applicable FY 00: TBR 6/01 FY 99: N.A. (See p. 19 of GPRA narrative for interim data.) FY 98 Baseline: 0 Sites	B69
2. For children 9+, decrease in use of: Alcohol Tobacco Marijuana	FY 01: Not applicable; program completed FY 00: Decrease by 10% Decrease by 10% Decrease by 5% FY 99: Not applicable.	FY 01: Not applicable FY 00: TBR 6/01 To be reported at end of program. See narrative for interim data showing some trend differences between the intervention and control groups in the age 12-14 cohort. FY 99: Not applicable; one time reporting FY 98 Baseline: Age 9-11 Alcohol Use 4.5% Tobacco Use 2.5%; Marijuana Use .8%. Age 12-14: Alcohol Use 8.3% Tobacco Use 7.5% Marijuana Use 2.3%	B69
Total Funding:	**1997: $5,700,000** **1998: $5,708,000** **1999: $2,561,000** **2000: $ Program Ending**		

2.12.1 Program Description, Context, and Summary of Performance

The goal of this program is generate new empirical knowledge about effective approaches for changing the development of trajectories of children at risk for substance abuse.

In 1996, SAMHSA/CSAP decided to direct its funding to knowledge development, and knowledge application. At that time it was determined that knowledge was available from previous research which indicated that there are markers for deviant behavior, including substance abuse, and that these markers can be targeted for interventions designed to change the developmental trajectory of children who might otherwise develop substance abuse. There was no significant information available, however, that suggested appropriate interventions for specific developmental stages. Thus, it became the goal of the Predictor Variables initiative to determine at what developmental stage(s) does enhancement of each of the variables being investigated prove most effective in preventing/reducing negative behaviors that are predictive of substance abuse.

The Predictor Variables Program studies the effect of prevention interventions targeted to four variables that are predictive of later substance abuse and other deviant behaviors. The four variables in this study include: self-regulation and control; cognitive development/academic achievement; school bonding; and care giver investment in the child and activities. The ten study sites are located in both rural and urban areas. They are divided into four age cohorts; 3 - 5, 6 - 8, 9 - 11, and 12 - 14, and are testing interventions appropriate to those developmental stages. They have, at this point, some significant interim findings, and it is expected that they will develop dissemination packages for use by others who would like to replicate individual projects.

The contribution the Predictor Variables Program will provide for a greater understanding of the age groups that are in need of greater interventions. The Program will also assist in the identification of the ages at which to target the specific variables (self-regulation and control, cognitive development, academic achievement, school bonding, and care giver bonding) that are associated with subsequent substance use. This will assist federal, state and local entities in allocating their resources most effectively because it will help them target those specific factors most associated with substance use for a particular developmental group. These findings also influence CSAP's future program direction by better enabling us to issue focused announcements, provide related technical assistance and training, and optimize dissemination of these findings.

Long Term Indicators of Success for the Predictor Variables Program In support of SAMHSA goal 3- bridge the gap between knowledge and practice

While final results will be reported in FY01, preliminary findings show significant improvement in the intervention group relative to the control group in:

< improved parenting practices,
< increased family cohesion,

- increased family organization and
- decreased family conflict.
- aggressive disruptive behaviors and
- concentration problems.

Interim results also reveal that:

- The rates of chewing tobacco were reduced from 2.6% to .5 % in the intervention group, while the comparison group rates doubled from 1.1% to 2.3%.
- The use of alcohol was 4% lower in the intervention group compared to the control group.
- The rates of overall use of one or more drugs in the control group have almost doubled from 6.8% to 12.4%, while this increase is less than half a percentage point (.4%) in the intervention group.

2.12.3 Goal-by-Goal Presentation of Performance

Performance Goals: Goal 3: Bridge the gap between knowledge and practice. Measures emphasize outcomes and the implementation of effective models.

Measure 1: 80% of sites (8 out of 10) will implement effective intervention models, designed to be disseminated through professional journals, meetings, and other dissemination arenas.

Rationale: Aside from generating findings on the effectiveness of the interventions and determining the prime window of opportunity for intervening with children to prevent substance abuse pre-cursors, this program expects to generate intervention models that can be disseminated to states and local communities interested in implementing age appropriate substance abuse prevention programs.

Data Source and Validity of Data: The researchers for each age cohort have selected common instruments appropriate to the developmental stage being addressed. The Research Coordinating Center is charged with responsibility for ensuring integrity of the data. The validity of the data is expected to be high as standardized instruments are being used. Effective models will be determined by criteria developed by CSAP to evaluate effective substance abuse prevention models.

Baseline: 0 sites (grant sites received awards in 1997).

Target: FY 2000, 8 sites

Progress Update: Although it is expected that all models will have some significant findings, it is apparent that some may be more readily replicable than others because of various factors within the environment of the individual sites. All studies will compete for one-year continuation supplements at the end of FY 1999. Providing for an additional year will allow projects to have sufficient data points for more sophisticated analyses (e.g. Growth Curve Analysis). Information from these analyses will not be available until mid-FY 2001, following the end of the projects at the end of FY 2000. Dissemination

model packages should be available within 6 months of the close of individual projects, late FY 2001. The following are examples of promising significant findings from individual sites:

1. Preliminary findings show significant improvements in improved parenting practices, increased family cohesion, increased family organization and decreased family conflict.
2. Parents in the intervention group significantly decreased their use of harsh strategies while controls show no changes.
3. Children in the treatment group showed significant reductions compared to controls from pre- to post-test for aggressive/disruptive behavior and concentration problems.

Measure 2: **Children 9 years of age and over in the treatment groups will decrease alcohol, tobacco, and drug use in comparison to children in the control group by the end of the projects. (Final data to be available in mid-FY2001)**

Rationale: Intervention research has provided indications that it may be possible to change disordered behavioral patterns of young children if interventions begin early and are targeted at several predictor variables including social competence, self regulation, school bonding and academic achievement and care giver investment. As previously described, research studies have found these indicators to be highly predictive of substance use. It is anticipated that this initiative will be successful in changing developmental paths toward deviant behavior and lead to more healthy social and emotional development as well as reduce the incidence of substance abuse disorders.

Data Source and Validity of Data: The 9 - 11 and 12 -14 age cohorts have collected ATOD data using standardized instruments such as scales from the National Youth Survey.

Baseline: Baseline data was submitted in FY 2000 Plan. Data has been collected at one additional point since that period.

Target: For FY 2000, alcohol use decreases by 10%, tobacco use decreases by 10% and marijuana use decreases by 5%.

Progress Update: Findings from the 9 - 11 cohort indicate that there are no significant differences between the intervention and control groups from baseline to mid-intervention in the frequency of tobacco, alcohol, and marijuana use, and in the combined index of use of one or more drugs. These results are to be expected given the age of this cohort, and the low substance use rates at baseline.

While findings from the 12 - 14 age cohort reveal no significant differences in the rates of use of tobacco, alcohol, and marijuana from baseline to follow-up in the intervention and control groups, several important points regarding the trend of substance use are noteworthy:

1) Whereas the intervention group manifests a reduction in the rates of chewing tobacco use from baseline to follow-up (from 2.6% to .5%), these rates have doubled in the control group (from 1.1% to 2.3%);

2) Although both groups show an increase in the rates of alcohol use, the number of youth who use alcohol in the control group is twice as high at follow-up in comparison to baseline (4.5% vs. 9%), and 4.0% higher in comparison to the intervention group; and

3) With respect to the index of overall use of one or more drugs, the rates in the control group have doubled (from 6.8% to 12.4%), while in the intervention group this increase is less than half a percentage point (.4%).

The trends observed in these results is, in fact, consistent with the objectives of the projects representing the 12 - 14 year old cohort; that is, the focus is on curbing current and preventing future substance use, as opposed to preventing early onset of substance use. It should be noted that this is mid-point intervention data and should not be considered final nor conclusive.

2.13 Program Title: Starting Early/Starting Smart: Early Childhood Collaboration Project SESS Interim Report

Performance Goals *Goal 3: Bridge the gap between knowledge and practice.*	*Targets*	*Actual Performance*	*Refer-ence*
1. SAMHSA and partners execute Memoranda of Understanding	FY 01: 2 additional funders FY 00: Maintain at 100% FY 99: 100%	FY 01: TBR 9/01 FY 00: TBR 6/00 FY 99: 100% FY 97 Baseline: 50% of collaborators have MOUs.	B69

2. Increase physical health, behavior, social and emotional functioning (social skill subscale, problem behavior subscale) language development (cognitive scale)	FY01 Target additional 5% increase in the differential between treatment and control group reports across physical and behavioral measures. FY 00 Targets: Physical Health - 5% increase in the differential between treatment and control group reports of good health. Behavioral Health - - 5% increase in the mean rating for children on the Social Skills Subscale and - 5% decrease in the mean rating for children on the Problem Behavior Subscales. Language/Cognitive - 5% increase in the scores for receptive and expressive language . FY 99: Collect baseline data	FY 01: TBR 9/01 FY 00: TBR 6/00 FY 99: Target met FY 98 Baseline: -Physical Health 42.9% of all care givers report good to excellent child health, Behavioral Health (see subscales in tables) Current data indicates more child problem behaviors reported by care givers, Cognitive (language development) 50% correct response rate;	B69
Total Funding:	**1997: $6,200,000** **1998: $8,277,000** **1999: $7,986,000** **2000: $7,422,000** **2001 Req: Funding is not separate for each Center all located in CMHS's Budget.**		

2.13.1 Program Description, Context, and Summary of Performance

The goal of this program is to test the effectiveness of integrating mental health and substance abuse prevention and treatment services for children ages birth to seven years and their families/care givers, with primary health care service settings or early childhood service settings. This early intervention model brings integrated behavioral health services to typical early childhood settings, where families are already engaged, such as child care, preschool, Head Start, primary care clinics and community clinics. SAMHSA, as the expert in behavioral health services (substance abuse prevention, treatment and mental health services), can enhance these successful early childhood programs (begun by MCHB, Head Start, etc) by bringing these much needed services to already existing programs. If this model is successful, these SESS programs should be sustainable through community collaborations, continued Foundation funding, or new partnerships. As a prevention program, SESS reaches children at an early age when brain physiology can be impacted, behaviors can be molded, and parents can be supported and empowered to raise healthy children.

This program is directed by the following core principles:

- Substance abuse prevention, treatment, and mental health services are essential components of early intervention for young children and their families.
- Reaching high risk young children and families in service settings where they already are engaged is the most effective method of providing services.
- Young children and families benefit most through a child-centered, family-strength based, solution-focused approach.
- Culture is a valuable resource in engaging and meeting the needs of young children and their families.
- Collaboration is the most effective strategy for successful outcomes for young children and families. This includes families, public/private agencies, professional associations, and providers as partners.

This program is carried out with the advice and investment of the Department of Education, Health Resources Services Administration, and the Administration for Children and Families. Grantees are located in Head Start sites, child care or preschools, and primary care health clinics. The results of this important program will provide important information to help a population for whom limited data are available: the very young children (0-7) and their care givers. This knowledge will likely impact environments of young (e.g. Headstart, primary care facilities); programs targeting families, perhaps even the workplace. Results will be disseminated using all of CSAP's training, technical assistance and distribution mechanisms.

Core measures for the cross-site study include key measures in each of 4 areas:

1. Parental functioning: Parental substance abuse; Parental mental health status;

It is well accepted that parental functioning has tremendous impact on children, especially the very young child who is experiencing significant brain growth.

2. Child functioning: Health status; Language development; School readiness; Social- functioning; Behavior. Direct measures of child functioning from both Teacher and Care giver are vital to determine field dependent behaviors; multi method approach incorporating both interview, questionnaire and observation support this measure.

3. Parent-child dyad: Parental discipline; Attachment; Home environment -It is well documented that the parent-child relationship is the window to assessing attachment and attachment behaviors for children. The home environment is critical to assess in order to ascertain a complete picture of the child's experience.

4. Service integration: Service access, utilization and satisfaction modules. In order to ascertain if integrating services in early childhood settings truly improves access to care and utilization of services, and increases satisfaction with services, a periodic assessment is administered to families.

FY 1997 baseline data on physical health, behavior, social and emotional functioning and language development have been collected and analyzed. Interim data is as follows:

- Physical Health--Asthma was the most commonly reported physical health diagnosis (180 of 1120 youth); Very few other chronic medical problems were reported (less than 4% of the sample reported any specific diagnosed problem); Overall, just under half (42.9 percent) of care givers rated their child's health as excellent, and approximately half of the care givers reported their child's health to be very good or good.
- Language---Clinical Evaluation of Language Fundamentals is the instrument which presents children with stories followed by comprehension questions and sentence recall. Children gave correct responses slightly more frequently than incorrect responses on both the Linguistic Concepts and Recalling Sentences in Context subscales.
- Social Skills---The rating scale for the PKBS indicates the frequency with which a child engages in particular behaviors. Care giver and teacher mean ratings of the target child's social skills were similar, with all subscale scores indicating that positive social behaviors were engaged in between "Sometimes" and "Often." Care givers tended to rate their child as having more frequent problems behaviors than did the Teacher.

2.13.2 Goal-by-Goal Presentation of Performance

Performance Goals: Goal 3: Bridge the gap between knowledge and practice. Measures emphasize outcomes and the implementation of effective models.

Measure 1: SAMHSA and 100% of the federal and private partners to this effort will have executed memoranda of understanding (MOU) that specify their mutual expectations

Rationale: One of the goals of SESS is to foster public/private collaborations to create a more comprehensive framework for improving services to young children and their families. Collaborations across government agencies and private sector organizations promote systems integration and streamline the process for providing services and promoting knowledge development.

Data Source and Validity of Data: CSAP records substantiating the execution of these official agreements.

Baseline: 5 FY 1997 0 percent of the initial collaborators have MOUs negotiated.

Target: FY 2000, maintain at 100%. FY 2001, establish 2 additional funders.
Progress Update: FY 1999 target was achieved: SAMHSA and 100% of the federal and private partners have executed MOU that specifies their mutual expectations. The target has been modified for FY 2001 to add two additional funders. Formal requests to support parent-child interaction component of SESS were sent to NINR, Department of Education, NIH, and several private Foundations working with families. Continued support through private funding further strengthens our outcome data and sustains our efforts.

Measure 2: By FY 1999, SESS will establish baseline data on physical health, behavior, social and emotional functioning and language development of participating children ages 0 - 5 (and their families) by compilation and analysis of collected data from the initial administration of the determined protocol instruments.

Rationale: Collection of baseline data commenced on July 1, 1998. Workgroups composed of members of the Steering Committee reached consensus on plans for cross-site data collection instrumentation, data points, and analysis. These plans are contained in the Phase I Report, has been critiqued by funding agencies (SAMHSA and the Casey Family Program) and an expert panel of consultants.

Data Source and Validity of Data: Multiple selected, sometimes modified, standardized instruments, agreed upon by consensus of the steering committee (grantees), are used. The SESS Data Coordinating Center assures data quality and the validity of the data.

Baseline: FY 1998 collection of baseline data commenced as planned. Approximately 3,000 (1500 experimental and 1500 control) target children will be studied, with an implied n for parents and parent-child dyads.

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Target: By FY 2000, establish targets on these measures for children. By late FY 2001, demonstrate empirical evidence of improved physical health, behavior, social and emotional functioning and language development of children in the integrated behavioral health services intervention group.

Progress Update: SESS sites have gathered baseline data on target children in the following areas:

Physical Health (from the Physical Health Module)
Social Skills and Problem Behaviors (from the Preschool-Kindergarten Behavior Scales)
Language Development (Clinical Evaluation of Language Fundamentals)

These data will provide the point of reference from which to compare further data points. Change in physical health, although not an specific outcome for SESS, will be noted. The Physical Health Module is composed of an Infant Version and a Child Version. Data demonstrates baselines as follows:

Asthma was the most commonly reported physical health diagnosis (180 of 1120 youth)
Very few other chronic medical problems were reported (less than 4% of the sample reported any specific diagnosed problem)
Overall, just under half (42.9 percent) of care givers rated their child's health as excellent, and approximately half of the care givers reported their child's health to be very good or good.

For FY 00: A conservative increase in differential between treatment and control groups is predicted based on: the existing chronic illnesses (approx 25%of sample) reported in this sample that may not change in a short term evaluation period; approximately half of the sample currently report good health.

Behavioral (social functioning) evaluations of children by care givers and teachers have been completed. This data will provide a point of reference from which to compare further data point assessments of emotional and social behaviors. The Preschool-Kindergarten Behavior Scales (PKBS) is administered to children 3 years of age or older, therefore the sample size for this instrument is restricted to the appropriate age group. At the present time, there is not enough data available on the Infant Toddler Symptom Checklist (a social/developmental measure for young children) to provide meaningful descriptive information, hence it will not be included here.

The rating scale for the PKBS indicates the frequency of child behavior.

Care giver and teacher mean ratings of the target child's social skills were similar, with all subscale scores indicating that positive social behaviors were engaged in between "Sometimes" and "Often."

Care givers tended to rate their child as having more frequent problems behaviors than did the Teacher.

For FY00: A 5% differential between treatment and control groups is predicted. This program is preventive in nature, and is applied to very young children who are growing and developing at a rapid rate. However, the immediate benefits of the interventions are not as dramatic, as the outcomes apparent at 5 years of age. Therefore a conservative percentage is predicted in the program evaluation period.

Clinical Evaluation of Language Fundamentals is the instrument which presents children with stories followed by comprehension questions and sentence recall. This instrument evaluates receptive and expressive language abilities. The scores were standardized by the age of the child.

> Children gave correct responses slightly more frequently than incorrect responses on both the Linguistic Concepts and Recalling Sentences in Context subscales. (More work needs to be done on the interpretation of the scores.)

For FY00: A 5% increase in the differential between treatment and control groups are predicted. This tool is clinical in nature, and will be evaluated carefully given that a large percentage of children have English as a second language.

Detailed tables 1 and 2 on preschool-kindergarten behavior scales are in Appendix B.4 to illustrate the baseline data for each module. Examples are provided in the Appendix.

2.14 Program Title: Youth Connect - High Risk Youth Mentoring/Advocacy Program (supported by separate High Risk Youth budget line)

Performance Goals *Goal 3: Bridge the gap between knowledge and practice*	*Targets*	*Actual Performance*	*Refer-ence*

1. Decrease substance abuse and related violence for treatment subjects relative to similar population without prevention programming	FY 01:5-15% reduction FY 00: 5% Reduction FY 99: N.A. First included in the FY 2000 plan.	FY 01: TBR 1/02 See GPRA report for interim information. FY 00: TBR 12/01 FY 99: Baselines: TBR 12/00	B89
2. Sites will document models that are determined to be both effective and replicable	FY 01: 60% effective and replicable FY 00: (Preliminary analysis to be completed) FY 99:N/A	FY 01: TBR 12/02 See GPRA report for interim information. FY 00: N/A FY 99:N/A FY 98: Baseline: 0 sites	B89
Total Funding: **(Note that this program is funded from the High Risk Youth budget activity.)**	**1998: $6,000,000** **1999: $6,991,000** **2000: $7,000,000** **2001 Req: $7,000,000**		

2.14.1 Program Description, Content, and Summary of Performance

The goal of this program is to prevent or reduce substance abuse or delay onset in youth ages 9-15, by improving school bonding and academic performance, family bonding and functioning, and life management skills. This KD&A program also relates to CSAP's emphasis in addressing the needs of vulnerable populations, including youth at high risk for substance abuse. Project Youth Connect, is designed to test a dual approach as follows: 1) Mentoring/advocacy intervention, working with youth only, 2) Mentoring/advocacy intervention with youth and their families.

Project Youth Connect focuses on youth 9-15 years of age and their families. The degree to which youth is involved in a pattern of behavior is related to the number and kinds of risks and protective factors present in that youth's life. A youth who has learning problems in school, has a parent who has been involved in the criminal justice system, comes from a family with a substance abuse problem, lives in an economically strained community, and/or who has been a witness to violence is said to have multiple risk factors. Intensive and caring relationships with a mentor/advocate will involve the youth in such a manner that a trusting relationship will promote improvement in all areas of their life.

Attachment to a parent is predictive of future behavioral problems in youth. If close attachment with a parent is not possible, then bonding with another caring adult can provide the needed bonding relationship. There is strong support in the literature that such relationships can have an important effect as a strong protective factor, despite the presence of other risk factors.

Mentoring advocacy can be one of those mechanisms for creating adult/youth bonding. Mentoring programs that require the mentors to receive adequate training before assuming their roles as mentors and those that allow for greater amounts of mentor time being allocated to the youth and/or his/her family have met with great success. An example of a successful mentoring program is the Big Brothers/Big Sisters Mentoring Programs. In a study of this program, the mentors met two to four times per month for at least four hours each time over a minimum of a one year period for 144 hours of contact. The results of the study demonstrated program effectiveness for the short term in that 46% of the participants were less likely to start using illegal drugs and 27% were less likely to use alcohol. In this program, mentor/youth interaction was more intensive than in many other such efforts and was enhanced by a highly supportive infrastructure.

The Project Youth Connect program will evaluate the effectiveness of mentoring interventions with 15 funded, diverse programs that employ professional and paid mentor/advocates, who will be required to spend an extensive and specific amount of time with their students and/or their families/care givers. CSAP will determine the effectiveness of mentor/advocates with the youth alone, or with the youth and their families. It is anticipated the intervention will be effective in reducing substance abuse and related violence, as well as improving community attitudes about youth and enhancing the system of support available to them and their families. In addition to alcohol, tobacco and other drug (ATOD) use and attitudes, the following information is being collected: 1) improved school bonding, grades and attendance (e.g., school bonding scale of NYS); 2) improved parent/care giver attachment and parental supervision (11 items from OJJDP's Causes and Correlates Study); 3) improved life management skills such as peer refusal, problem solving, self efficacy, cultural pride and peer relations (Hudson's Index of Peer Relations et al.).

The legacy of the Youth Connect Program will be an impact on the three domains of the community, adults, and youth. In the community lasting intergenerational bonds are created. Older adults become a valuable resource to the community. Family dissent will decrease and family bonds will increase. Positive parenting skills will result, and substance abuse by parents will decrease. The individual will increase self-efficacy, and there will be decreases in conduct disorders. Finally, this program will be a national example of a youth mentoring program for youth and families.

2.14.2 Goal-by-Goal Presentation of Performance

Performance Goals: Goal 3: Bridge the gap between knowledge and practice. Measures emphasize outcomes and the implementation of effective models.

Measure 1: FY 2000 preliminary goals for the 15 funded projects, include a 5% reduction in 30 day substance use relative to that of the control/comparison groups.

Rationale: Prior research has demonstrated that improving school bonding and academic performance, improving family bonding and functioning, and improving individual life skills can serve as protective factors to prevent youth abuse of substances. This initiative targets collection of individual data from

treatment and comparison groups to determine the success of the interventions in positively affecting these areas.

Data Source and Validity of Data: The program steering committee, composed of grantee members, has identified standard core measures incorporating questions from the SAMHSA core client tool and the National Youth Survey (NYS) to be used across all sites. The NYS is a validated instrument widely used in the field. The SAMHSA core client tool uses items from nationally known standardized instruments.

Baseline: Baseline data collection is being administered in the Spring and Summer of FY 1999. Baseline analyses and the first point of interim data collection will be completed in FY 2000.
Target: For FY 2001, the target is a 10% reduction in 30 day substance use relative to that of the comparison/control group.

Progress Update: These measures were piloted in March of FY 1999. Baseline data collection is being administered in the Spring and Summer of FY 1999. There will be a least 3 additional data collection points in all completed cohorts. All final data will be available in the Fall of FY 2002.

Measure 2: **By the end of FY 2000, 50% of the sites can be identified as promising programs for replication.**

Rationale: In addition to providing findings on effectiveness, it is expected that these studies will produce replicable models that can be disseminated to state and local communities interested in implementing effective mentoring/advocacy programs.

Data Source and Validity of Data: PYC Instrument: The Mentor/Mentee Alliance scale is being considered for determining the cohesiveness of the relationship. It is expected that other outcome and process data (particularly the dosage instrument which looks at time spent in various activities with the mentor) will also assist in determining the quality of individual relationships, as well as providing information on the overall effectiveness of the individual sites as replication candidates. Reliability range from .90 - .52.

Baseline: 0 sites identified.

Target: By the end of FY 2001, 60% of sites will be able to document models that are determined to be both effective and replicable.

Progress Update: All sites are in the process of preparing to implement and administer baseline data collection activities. The viability of the mentor/mentee relationship is an important aspect of replicating individual projects. The grantees have formed a workgroup to investigate that relationship from the standpoint of both the youth and the adult, as well as the youth's capacity to form relationships with adults. By the end of FY 2000, there should be data available to determine whether the programs are

showing promise for replication; and by the end of FY 2001, it should be clear which programs are definitely candidates for replication.

2.15 Program Title: Cooperative Agreements for Public/Private Sector Workplace Models and Strategies for the Incorporation of Substance Abuse Prevention and Early Intervention Initiatives into Managed Care (Workplace Managed Care) Interim Report

Performance Goals *Goal 3: Bridge the gap between knowledge and practice*	*Targets*	*Actual Performance*	*Refer-ence*
1: Reach agreement in FY 1999 on core process and outcome measures for cross site analysis.	FY 00 and FY 01: N.A. (Met and dropped in FY99) FY 99: All sites (9)	FY00 and FY01: One time, FY99 target. FY 99: Met (All sites reached consensus) FY 98 Baseline: No sites	B69
2: Health care utilization will increase as defined by pre-post data in prospective studies	FY 01: All sites (9) FY 00: Not applicable; one-time reporting. FY 99: N.A.	FY 01: TBR 10/01 See GPRA plan for interim information. FY 00: TBR 10/00 (See GPRA plan for interim information) FY 99 Baseline: <u>Outpatient Healthcare Utilization</u>: -Days with Emergency Room Service 1.1 to .03 for 5 of 9 grants -Days with urgent /emergency care service 0-1 for 1 of 9 grants; -Days without patient service 7-1 for 6 of 9 grants. <u>Inpatient Health Care Utilization</u>: -Number of inpatient admissions 1-.01 for 6 of 9 grants -Average total of inpatient stay 3-.04 for 5 of 9 grants.	B69
Total Funding:	**1997:$4,500,000** **1998: $4,594,000** **1999: $4,672,000** **2000: $ 3,000,00**		

2.15.1 Program Description, Context, and Summary of Performance

The goal of the program is to determine which public/private sector workplace managed care substance abuse prevention and early intervention programs are the most effective in reducing the incidence and prevalence of substance abuse and to disseminate these findings. The objectives are: (1) to determine the nature (e.g. structure, organization, function, etc.) of workplace managed care (WMC) programs utilizing substance abuse prevention and early intervention efforts; and (2) to provide a detailed description of the WMC programs; assess their strengths and weaknesses and their impact on the substance abuse of employees and their families (e.g. covered lives); and assess the quality and delivery of substance abuse prevention and early intervention. Study questions include:

- Do substance abuse prevention and early intervention strategies and programs, applied within various managed care models, prevent and/or reduce substance abuse for covered lives (employees and their families) over time?
- Does the prevalence or incidence of substance abuse differ among substance abuse prevention and early intervention models of managed care?

2.15.2 Goal-by-Goal Presentation of Performance

Performance Goals: Goal 3: Bridge the gap between knowledge and practice. Measures emphasize measures development and health care utilization.

Measure 1:CSAP and the 9 funded cooperative agreements will agree to core process and outcome measures for the cross-site analysis (FY 1999 target).

Rationale: One of the goals of the WMC program is to complete a cross-site analysis of the funded cooperative agreements and to be able to study findings across the sites.

Data Source and Validity: WMC uses only secondary data from CSAP records, grant reports and the WMC cross-site data base. No primary data are to be collected. Data definitions and sources were achieved through grantee consensus based on data already available at sites.

Baseline: FY 1998, no consensus at program start across sites.

Target: Not applicable, one-time target met.

Progress Update: Consensus has been reached by 100% of the sites and CSAP on process and outcome cross-site measures.

100

Measure 2: Health Care Utilization will increase as defined by pre- post data from prospective studies.

Rationale: Research indicates that there are a number of important intervening and outcome variables available in health claims records that provide an empirical basis for studying the success of substance abuse prevention and early intervention programs in workplace managed care settings. In order to assess the success of the study, baseline data (or pre-intervention)will be collected prior to any intervention being given to the study group. Additionally, data at the conclusion of the study (post-intervention) will be collected. In this fashion, the significance of the intervention can be determined. Intervening variables such as age, sex, and marital status are important to interpreting the outcome findings. Utilization and cost of emergency room services, utilization and cost of urgent/emergency care services; utilization and cost of outpatient services; utilization and cost of inpatient services; utilization and cost of substance abuse services and related medical conditions; utilization and cost of mental health services, have been shown to be good predictors of the success of substance abuse prevention/early intervention programs.

To build the health care utilization indicators, variables including relationship to subscriber, plan enrollment and termination dates, location of service, cost of service, and ICD-9 diagnosis codes will be used across the nine cooperative agreement sites. Financial outcome data have been shown to be good predictors of the success of substance abuse prevention/early intervention programs and are in the process of being defined.

Data Source and Validity: Cross-site database of secondary data from grantee records. ICD codes are commonly used for these types of data. The WMC Cross-Site Evaluation Team finished working with each of the study sites to prepare files of the data to confirm the availability of the data and the accuracy and reliability of the data merge process and data transfer protocols

Baseline: FY 1998 results of baseline analyses are presented below

Target: FY 2000 Health Care Utilization will increase as defined by pre- post data from prospective studies.

Progress Update: The Steering Committee has agreed upon the ICD-9 codes to be collected. Consequently, grantees began to collect the appropriate medical utilization codes in April 1999. Data will be analyzed once the intervention is completed and should be available by the end of FY 2000. Some preliminary evidence includes:

- G-4 has collected workers's compensation claims, health care costs at 14 sites for 1996-1997 for more than 1,300 employees indicating combined number of claims of 287 with a range of 0 - 35.1% filing for the two years combined and healthcare costs of $708,053 for these claims. It built a retrospective database for 96 variables including drug testing and is completing its analysis.

- G-8 has completed creating its alcohol abuse prevention web site to assess employee's risk for alcohol abuse/dependence which is designed as a prospective intervention; and analyzed retrospective health care utilization data. They found for 1997 there were 28,765 covered lives with a prevalence of .118% having substance abuse treatment needs. Preliminary analysis of OSHA 200 logs suggest 7.5% of the cases are alcohol-related.

The following GPRA baseline data report has been compiled from all of the 9 WMC Cooperative Agreement "GPRA BASELINE REPORTING" data reports for one quarter of data from each. Additional information may be found in the Appendix.B.4.

Outpatient Health Care Utilization Baseline Subscriber Data

Outpatient Measure	Percent of Subscribers w/ at least one day of service	Mean number of Days on which a service was provided	Mean Total Cost of services provided
Days w/ Emergency Room Services:			
Overall	10% - 2.54% for 5 of 9 grants	1.1 to .03 for 5 of 9 grants	$485 - $11.14 for 5 of 9 grants
Related to Substance Abuse	0 - .1% for 5 of 9 grants	0 - 1 for 5 of 9 grants	$188 - 0 for 5 of 9 grants
Days w/ Urgent/Emergent Care Services:			
Overall	.5% for 1 of 9 grants	1 for 1 of 9 grants	$55.55 for 1 of 9 grants
Related to Substance Abuse	0	0	0
Days w/ Outpatient Services:			
Overall	99.53% - 51.4% for 6 of 9 grants	7 - 1 for 6 of 9 grants	$916 - $102 for 6 of 9 grants
Related to Substance Abuse	46 - 0 for 5 of 9 grants	1 - 0 for 6 of 9 grants	$309 - $.42 for 5 of 9 grants

Definitions to Use:

Subscriber = the employee

Mean Days = mean number of days on which a service was provided across subscribers

Mean Cost = mean total paid amount for service provided across subscribers

Percent = percent of total subscribers with at least one instance of the service

2.16 Program Title: National Clearinghouse for Alcohol and Drug Information (NCADI)
Annual Report of Ongoing Program

Performance Goals *Goal 3: Bridge the gap between knowledge and practice*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase number of information requests	FY 01: 260% increase over baseline (was 20%) FY 00: 245% increase over baseline (was 15%) FY 99: 5% increase over baseline (targets have been revised upward)	FY 01: TBR 10/02 FY 00: TBR 10/01 FY 99: 135 percent increase over baseline. 40,285 requests/month (59 percent of inquiries are made by phone; 3 percent by mail; 30 percent by e-mail; and 2 percent by fax/in-person) FY 98: 43 percent increase 25,289 requests/month (Telephone: 14,437/month, Mail: 2887, E-mail: 6810, PREVLINE: 1155) FY 97 Baseline: 17,600 requests/month (Telephone: 13,750 requests per mo., mail: 2,750 requests per mo.; PREVLINE: 1,100 requests per month.)	B69
2. Maintain customer satisfaction (Note: 1999 Measure 2 was dropped in the FY 2000/Revised FY 1999 plan.)	FY 01: 85%* FY 00: 85%* FY 99: 85% *The new OMB-approved customer satisfaction survey will be used for the first time in FY00, which is why the target remains at 85% until a new baseline is established.	FY 01: Target exceeded in FY 98. FY 00: TBR 10/01 FY 99: Exceeded 90% FY 98:Exceeded 90% FY 97 Baseline: 85%	B69

Total Funding:	**1998: $9,162,000** **1999: $2,023,000** **2000: $4,729,000** **2001 Req: $7,000,000**		

2.16.1 Program Description, Context, and Summary of Performance

The goal of this program is to increase substance abuse and mental health public information dissemination activities. This program distributes SAMHSA/CSAP/CSAT, NIAAA, NIDA, Department of Education, ONDCP, and other organizational print and audiovisual resources to the prevention, intervention, and treatment field. NCADI is responding to the demand generated by the ONDCP National Youth Anti-Drug Media Campaign, which has stimulated just over twice the level of demand as compared to last year. Also, NCADI has implemented call center operations 24 hours a day, 7 days a week, to serve the ONDCP media campaign as well as various CSAP public education campaigns, and has taken on responsibility for CSAT's National Treatment Helpline.

If funds are appropriated in FY 2000 and 2001 to support the Dissemination Initiative for Effective High Risk Youth Models, then NCADI will expand its involvement in promoting and disseminating these publications as well as assist in targeted outreach to national intermediary organizations to garner support for and adoption of the effective high risk youth models by their members. Existing performance measures used for dissemination and outreach will be applied or tailored, as appropriate, to these activities.

NCADI has surpassed all of its targets for increasing the number of information requests received by telephone, mail, email and via prevline. The 90% customer satisfaction rating reflects an increase of 5% over the FY1997 baseline.

2.16.2 Goal-by-Goal Presentation

Performance Goals: Goal 3: Bridge the gap between knowledge and practice. Measures emphasize increases in information dissemination and customer satisfaction.

Measure 1: By FY 2001, increase the number of information requests received annually by 260% over the FY 1997 baseline

Rationale: The distribution of SAMHSA/CSAP/CSAT, NIAAA, NIDA, Department of Education, ONDCP, and other organizational print and audiovisual resources to the prevention, intervention, and treatment field is a standard measure for gauging the responsiveness to the public's need for information.

Items to be measured and reported include:

- the frequency of use of the following services of NCADI: telephone; mail; PREVLINE website (www.health.org); staff, walk-in visitors;
- related to the ONDCP media campaign in 1999-2000: Where did the requestor get the 800 number? When did the requestor see/hear the advertisement? Is the requestor getting materials to help talk with a child about substance abuse?

Data Source and Validity of Data: The NCADI contract has several tracking systems in place to account for the processing of phone calls, mail, e-mail, staff requests, and visitors. Each of these measures is reported to CSAP on a monthly basis and includes analyses of trends over time.

Baseline: FY 1997, 17,600 requests/month -- telephone: 13,750 requests per month; mail: 2,750 requests per month; PREVLINE: 1,100 requests per month; staff, walk-in visitors: 733 requests per month.

Target: FY 2000 target, 245 percent over FY 1997 baseline.

Progress Update: The current level of demand (as of October 1999) for NCADI services during a typical month is reflected in the following profile: 33,316 requests/month; 59 percent of inquiries are made by phone; 3 percent by mail; 30 percent by e-mail; and 2 percent by fax/in-person. The ONDCP National Youth Anti-drug Media Campaign, which was launched July 9, 1998, has had a significant impact on the number of calls to NCADI. After the first two weeks of the campaign, the NCADI contract experienced a 121 percent increase in caller volume as a result of the media advertising in 75 media markets. Historical records indicate that caller volume increases steadily each year regardless of whether broad-based media efforts are implemented. These targets have been revised upward due to NCADI's success in FY98 and FY99.

As of March 1999, ONDCP campaign's media efforts has stimulated an enormous increase in demand for substance abuse information. For example, in comparing 1997 and 1998 operating statistics, there has been an increase from:

- 973 tons of substance abuse materials to 1,050 tons shipped to requesters in one year, a 8 percent increase.

- In 1997, there were 13.3 million hits to PREVLINE, and in 1998, there were 34.5 million hits to PREVLINE, a 159.4 percent increase.

The increase in electronic communications with NCADI to request information has dramatically risen as well. This increased level of contact volume as well as growing demand for print and audiovisual resources is expected to continue to escalate dramatically as the ONDCP media campaign expands its efforts in Phases 2 and 3 to reach a greater number of markets and audiences (with special outreach in different languages). Clearly, the Clearinghouse has exceeded its FY 1999 5% targeted increase in the number of information requests received.

Measure 2: In FY 2001, customer satisfaction will remain high (at least 85%). (FY 2000 and 1999 targets: customer satisfaction will remain high at 85%).

Rationale: This measure offers direct feedback on the experience of customers trying to access and use clearinghouse services and resources. New measures will be added as additional services are implemented.

Data Source and Validity of Data: NCADI staff draws a random quality control sample from completed orders each month and customers are called on an ongoing basis during the following month. A customer service satisfaction report is generated every 6 months and submitted to CSAP. There are limitations to the data in that nonrespondents represent roughly 50% of the sample.

Baseline: In FY 1997, the customer satisfaction rate was 85 percent.

Target: In FY 2001, customer satisfaction will remain high (at least 85%).

Progress Update: FY 1999 customer satisfaction rates exceeded 90 percent. By FY 2000, SAMHSA will have substantive qualitative and quantitative data on the NCADI contract's performance in areas such as customer service (e.g., courteous and timely response to requests), marketing penetration of various products and services (e.g., audience impressions of radio and print public service announcements), usage patterns of products and services (e.g., types of information being downloaded from PREVLINE), and utility of products and services (e.g., how was the information used and was it as intended). Currently, the NCADI contract has traditional tracking information (e.g., number of contacts, mode of contact, number of website hits, number of publications shipped, general customer satisfaction assessments). While helpful to describe levels of activity for the purpose of efficient resource allocation, the new NCADI contract has only recently received clearance for its OMB package for its refined evaluation efforts to use performance measures that more directly impact Federal program directions and activities. The expanded baseline data generated in FY 2000 will drive development of the future performance measures. Because of the Census activity in early 2000, implementation of the survey will not take place until March 2000.

2.17 Program Title: National Public Education Efforts (linked to YSAPI) Interim Report

Performance Goals: Goal 3: Bridge the gap between knowledge and practice	*Targets*	*Actual Performance*	*Refer-ence*
1. Media placements & media access	FY 01: minimum 100% over baseline FY 00: minimum 100%over baseline FY 99: minimum 100% over baseline	FY 01: TBR 10/02 FY 00: TBR 10/01 FY 99: More than 100% over baseline FY 98: Significantly more than 100% over baseline 1997 Baseline: 5 - 15% response rate to media outreach efforts	B69
Total Funding:	**1997: $1,000,000** **1998: $6,300,000** **1999: $6,860,000** **2000: $6,860,000** **2001 Req: $8,700,000**		

2.17.1 Program Description, Context, and Summary of Performance

This program currently consists of three national media campaigns at various implementation phases: the "Reality Check! Marijuana Campaign," the "Girl Power! Campaign" and the "Positive Activities Campaign."

The "Reality Check" campaign is a multimedia campaign designed to prevent new use and reduce existing use of marijuana among 9- to 14-year olds. The Reality Check campaign is currently developing an array of tools and materials for a variety of users to enable them to address the problem of marijuana and youth at the community level. The Internet is an important channel for marijuana public education because of the need for ongoing environmental scanning and rapid response to provide facts and useful information and counter arguments to those that are widely promoted by the pro-

marijuana community which is very active on the Internet. Project staff monitor pro-marijuana sites to stay abreast of the messages and activities being promoted.

For example, in the Spring of this year, a million marijuana march by the pro-marijuana community, was scheduled to take place in several major cities around the country. The purpose of the march was to promote decriminalization. Along with all the details about the march, were downloadable stickers carrying the message "teach children that marijuana is medicine". In response to this event, Reality Check project staff prepared a package of information, including talking points and facts about marijuana to counter the March's promotional material, along with a letter that was sent to RADAR Network Centers and CSAP's Centers for the Application of Prevention Technologies CAPTs. Reality Check informed them of the planned activities and helped them be prepared to in the event that the planned pro-marijuana activities attracted media coverage. In a similar fashion, during October, an FBI Crime report was released about the number of arrests for marijuana use. This was picked up by the Marijuana Public Policy (MPP) a pro-marijuana group who put their own spin on it in accusing the government of wasting money arresting people for marijuana use. To counter this spin, Reality Check staff took the same information and in an article placed on the Reality Check website, discussed ways to use the information with teens to discourage experimentation and use.

The Reality Check Campaign website was redesigned to make the site easier to navigate and more user-friendly. The site, located at www.health.org/reality offers a new "Reality Bytes" section, which provides quick questions and answers about the effects and consequences associated with marijuana use. The site also added a "Newsroom," which features original articles and links related to marijuana, youth, and prevention issues. The Reality Check Newsroom is constantly updated in order to counter the many misleading, inaccurate, and pro-marijuana messages that are too often presented as "news". Whenever marijuana makes the headlines, interested parties can go to the Reality Check Newsroom for the pro-health, anti-use angle.

In July, a conference of more than 5,000 editors, reporters, and media executives representing major ethnic groups was held in Seattle. The opportunity to interface and educate members of this sector was seized by Reality Check Staff who attended the conference, exhibited and participated in a workshop sponsored by ONDCP. Information and materials focusing on the marijuana problem was packaged for easy use by journalists. Staff found many journalists expressed ambivalence about marijuana education, many admitting past or current use. However, when presented with Reality Checks' slogan "it's not about you, no matter what you think about marijuana, don't you agree that youth should not use or have access to marijuana", their interest increased, particularly in possible story ideas and angles.

The "Girl Power!" campaign continues to build public-private partnerships at the national, state, and local levels to expand the reach of the campaign. To date, the number of Girl Power! stories, website hits, and products distributed have reached almost 15 million. During September there were 1,499,731 hits, with an average of 49,991 hits per day. Viewing time averaged 7 minutes, 44 seconds. Three hundred and fifty-five e-mails were directed to gpower@health.org, and 248 GirlSpeak entries were

received. The most popular pages were the Girl Power! Homepage with 23,716 hits and the Order Girl Power! Materials page with 23,106 hits.

New website features include the National Library Card Sign-up Month and Get Back to School with Girl Power! A link was created to the National Institute of Health's Office of Science Education's "Women as Surgeons" free video and poster site (www.health.org/gpower/adults who care/index.htm). The "Your Time -- Their Future" campaign emphasizes positive activities, and targets parents and care givers of youth ages 7-14. The campaign is intended to encourage adults to become role models who can guide young people. Since the launch of the *Your Time--Their Future* Public Education Campaign in September 1998, the following performance has been achieved:

< Television PSAs – The 2,572 airings on 94 stations reached an estimated 375 million viewers and attained a comparative advertising value of $1,203,900.

< Show A Child You Care – The North American Precis Syndicate reports that, since May, this camera-ready article was printed in 220 newspapers reaching over 9 million readers in 13 States.

< Product Distribution – More than 418,400 products were distributed through September 20, 1999.

< Web Site – Between November 1998 and October 1999, the average number of Web hits per day increased from 1,860 to 3,508. In the first 13 months (through October 31, 1999), the Campaign Website received 998,174 hits.

Long range indicators of success for Public Education in support of SAMHSA goal 3 - bridge the gap between research and practice

< Media access and placements have increased more than 100% over the FY 1997 baseline.

2.17.2 Goal-by-Goal Presentation of Performance

Performance Goals: Goal 3: Bridge the gap between knowledge and practice. Measures emphasize increases in information dissemination.

Measure 1: In FY 2001, there will remain a 100% increase in media placements and media accesses to PREVLINE and the phone system over the FY 1997 baseline.

Rationale: An indicator for success of marketing efforts is to achieve a high level of mass media penetration. This activity is used to establish and sustain relationships with a broad range of media. Regular communications with the media results in a steady state of placements and access and a general awareness of SAMHSA/CSAP as a primary resource for information. When media interest in the issues is high, the number of media contacts rises dramatically.

Data Source and Validity of Data: The NCADI contract has several tracking systems in place to capture these data and report them to CSAP on a monthly basis. All customer satisfaction questionnaires have been cleared by OMB.

Baseline: FY 1997 5 percent response rate to media outreach efforts.

Target: For FY 2000 and FY 2001, a minimum100% response rate over the 1997 baseline response rate.

Progress Update: As a component of YSAPI and as a result of ONDCP's significant investment in media approaches to prevention, CSAP does not anticipate a problem in achieving the Measure 1 target.

2.18 Program Title: Centers for the Application of Prevention Technologies (CAPT) Interim Report

Performance Goals *Goal 3: Bridge the gap between knowledge and practice*	*Targets*	*Actual Performance*	*Refer-ence*
1:(a)Increase the number of technical assistance contact hours	FY 01: 30% FY 00: 25% increase from baseline FY 99: N.A.; first included in FY 2000 plan.	FY 01: TBR 11/02 FY 00: TBR 11/01 FY 1999 Baseline: SIG 1831; Non-SIG 1607; *Total 3496 across a 12 month period	B83
(b)Increase the number of prevention technologies introduced to all SIGS & their local subrecipients.	FY 01: TBA FY 00: 25% increase FY 99: N.A.	FY 01: TBR 11/02 FY 00: TBR 11/01 FY 99 Baseline: SIG 4223; Non-SIG 3054; *Total 7367	
2: Past month substance use will decrease among youth 12-17 years old (YSAPI measure)	FY 01: 15% decrease from baseline FY 00: 15% decrease from 1997 baseline FY 99: N.A.; first included in FY 2000 plan	FY 01: TBR 11/02 FY 00: TBR 11/01 FY 99: TBR 11/00 FY 98 Baseline: 9.9% FY 97: 11.4% FY 96: 9%	B83
Total Funding:	**1997: $5,200,000** **1998: $6,410,000** **1999: $6,449,000** **2000: $6,449,000** **2001 Req:$16,000,00**		

2.18.1 Program Description, Context, and Summary of Performance

The goal of CAPTs is to help practitioners to **"**Apply Prevention that Works**"** by bridging the gap between scientific development of prevention knowledge and effective application of that scientific knowledge. CAPTs seeks to increase the number of scientifically defensible programs, practices, and policies adapted and sustained by the state incentive grantees and their local subrecipients. This program promotes awareness, understanding, implementation and evaluation of state of the art prevention technologies through the establishment of six regional centers. Since 1997, the CAPTs have been rapidly transferring knowledge about effective science-based substance abuse prevention strategies, programs, and policies to assist both large clients (States, US Territories, Tribes and Jurisdictions) and small clients (communities, prevention organizations and providers) in implementing effective prevention practices that meet state and local needs. Three core knowledge application strategies that the CAPTs have used are: 1) Establishment of a technical assistance network using local experts for each region, 2) Skill development activities, and 3) Innovative use of communication media (e.g., teleconferencing, online events, video conferencing, and World Wide Web-based decision support with database transfer capabilities. During the past two years, the five regional CAPT Program grantees (The Border CAPT for one year) have been engaged in many of these activities. For example they have:

- Provided CAPT training and technical support services in person or via electronic communication to the 21 continuing SIG state systems, the 29 non-SIG states, and US Territories/Jurisdictions in the Pacific and Caribbean;
- Delivered to the Office of National Drug Control Policy (ONDCP)/ Office of Juvenile Justice and Delinquency Prevention (OJJDP) funded Drug-Free Communities Support Program (DFCSP) grantees regional training workshops and technical support;
- Provided non-SIG States within each region prevention technology transfer support via publications, training and technical support activities;
- The CAPTs will pilot test alpha and beta versions of CSAP's Decision Support System for Substance Abuse Prevention Science (DSSPSA)

CAPTs seeks to increase the number of scientifically defensible programs, practices, and policies adapted and sustained by the state incentive grantees and their local subrecipients. This program promotes awareness, understanding, implementation and evaluation of state of the art prevention technologies through the establishment of six regional centers.

The CAPT grantees have identified their process and outcome core measures to assess the training and technical assistance needs of the prevention practitioners seeking assistance. The evaluation results of the National CAPT program (National CAPT Program means standard operating procedures for all six Regional CAPT Centers) will indicate achievement of goals such as: increased accessibility to an application of proven substance abuse prevention strategies; expanded State and local capacity in the substance abuse prevention knowledge application process; increased access to

and use of electronic technologies in the region; and established regional capacity for ongoing mentoring and coaching. The National CAPT program also expects to learn about the "science and art of knowledge application." For example, which delivery methods are most effective in helping communities adopt and sustain the use of science-based prevention programs, practices, and policies? What configurations of skill development and capacity-building activities produced the greatest systems change?

- FY 1998 baseline data for this program have just been collected. They show that, in a nine month period, the CAPTS provided to states a total of 3257 hours of technical assistance and a total of 5567 hours introducing new prevention technologies.

- 30 day illegal drug use among youth ages 12-17 has decreased from 11.4% in FY 1997 to 9.9% in FY1998 according to NHSDA.

(This delay is due to the lag time between CAPT awards and SIG grants and contracts to local subrecipients who are the primary recipients of the CAPT services.)

2.18.2 Goal-by-Goal Presentation of Performance

Performance Goals: Goal 3: Bridge the gap between knowledge and practice. Measures emphasize technical assistance, the introduction of new technologies, and decreased substance use among youth.

Measure 1: By FY 2000, there will be a 25% increase in (a) the number of technical assistance contact hours and (b) the number of prevention technologies introduced to all SIGs and their local subrecipients.

Rationale: States require sound technical support to ensure that their selection of prevention strategies, programs and policies (prevention technologies) are based on scientific evidence. These regional centers are designed to provide the necessary support in conjunction with CSAP, other HHS agencies such as NIDA and NIAAA, and other departments such as Justice and Education. The intent is to increase the number of proven prevention technologies adopted at the community level; assess how well the technology transfer activities were implemented; and provide ongoing technical assistance and capacity-building to these communities to ensure their successful adoption of prevention technologies. The above measure will be refined for FY2001 should funding extend beyond FY 2000.

Data Source and Validity of Data: CAPTs data are obtained based on information obtained in identifying and responding to requests for training, etc. This is primarily information about needs and how those needs can be efficiently met. Face validity is likely given the simplicity and direct nature of the questions.

Baseline: For FY 1998, recent establishment as both the State Incentive program and the CAPT program had a start up in 1997.

Target: For FY 2000, 25% increase from baseline. For FY 2001, 30% increase from baseline.
Program Update: To ensure that the program needs of States and communities are met, the National CAPT program tailors its capacity-building services. From the individual level through comprehensive systemic change at the community/state/regional level, the National CAPT program is committed to working together with community and State organizations to design technical assistance and skill development services that will significantly enhance their respective prevention systems as well as the overall prevention infrastructure across the region. Due to the regional nature of the CAPT grantees, we expect that the close working relationships and responsiveness to their customers will result in the targeted increases described in measure 1.

The majority of the number of CAPT TA contacts is at the Statewide level. There is also contact at the local/ municipal levels and county levels. Through CSAP, the CAPTs have also been collaborating with other Federal agencies and National organizations. The collaboration between CSAP, ONDCP, and OJJDP for the CAPTs to provide TA and Regional Conferences to the Drug-Free Communities Support Program Grantees is a key example of collaboration at this level.

The CAPTs serve an increasingly important and vital intermediary functions for CSAP and other agencies that build the bridge between prevention knowledge and scientifically sound practice.

Measure 2: By FY 2001, past month substance use will decrease by 15% from the baseline among youth ages 12-17 (YSAPI measure).

Rationale: Comprehensive public education efforts can effect a change in the perception of risk/harm and associated drug use by youth 12-17 years old.

Data Source and Validity of Data: NIDA Monitoring the Future National High School Survey and SAMHSA National Household Survey on Drug Abuse. These are national surveys with known and established reliability and validity.

Baseline: FY 1997 baseline is 11.4%.

Target: For FY 2000 and FY 2001, 15% decrease from baseline.

Progress Update: To get research findings into practical use at the local level, SAMHSA/CSAP uses an integrated delivery approach (i.e., knowledge development, knowledge synthesis, knowledge dissemination, knowledge application). Initially, new research information must be synthesized and repackaged for different types of users e.g., ranging from prevention professionals to community activists (e.g. SAMHSA/CSAP's National Center for the Advancement of Prevention). Information is

then disseminated through multiple communication channels e.g., print, radio, TV, Internet, exhibits, to introduce it into the prevention field (SAMHSA's substance abuse and mental health clearinghouses, and media services). However, provision of information alone does not cause behavioral change. In order to effectively bring about changes which will significantly enhance the delivery of substance abuse prevention services at the local level, the National CAPT program's knowledge application services (i.e., applying prevention that works) complete the cycle. The CAPTs program is one of the components of the integrated and simultaneously implemented YSAPI components that together will prove successful in achieving our target in Measure 2.

Mental Health Services

The mission of the Center for Mental Health Services (CMHS) is to improve the quality and availability of mental health services. Working in partnership with governmental agencies at Federal, State, and local levels, as well as professional and community based organizations, CMHS activities are designed to improve access and reduce barriers to high quality services for people with, or at risk for, mental illnesses and disorders.

The following are just a few highlights of our programs successes:

< The Comprehensive Community Mental Health Services for Children and Their Families Program in 1999 served an estimated 15,600 children in increasing access to treatments and high quality mental health services through community rather than in residential placements.

< The Comprehensive Community Mental Health Services for Children and their Families findings indicate that for children served by CMHS programs, the number of contacts with law enforcement decreased, school grades improved, there were fewer school absences, their mental health improved, and the number of stable living arrangements increased.

< The Projects for Assistance in Transition for Homeless (PATH) program have been successful in reaching persons who have the most serious impairments, for whom at least 59% had co-occurring serious mental illnesses and substance abuse disorders, more than half of whom were living in the streets, in shelters or in temporary housing and had been homeless for more than 30 days.

Programs reported in the GPRA report include:

Goal 1: Assure services availability

2.19 Mental Health Block Grant
2.20 Protection and Advocacy
2.21 PATH Homeless

Goal 2: Meet unmet and emerging needs
2.22 Children's Program

Goal 3: Bridge the gap between knowledge and practice
2.23 ACCESS Homeless
2.24 Employment Intervention
2.25 Knowledge Exchange Network
2.26 Community Action

A full listing of CMHS programs and activities is as follows:

Activity Table - Center for Mental Health Services

*An asterisk indicates that performance information is reported in the FY 2001 performance plan and report. Activities not asterisked are time-limited activities that will be reported out approximately one year following their completion. These activities are measured in a manner similar to other activities within their goal area.

	First Funded	Completed	First Reported
Goal 1: Assure services availability			
MHBG		Ongoing* (2.19)	
P&A		Ongoing* (2.20)	
PATH		Ongoing* (2.21)	
Goal 2: Meet unmet and emerging needs			
Children's MH		Ongoing* (2.22)	
Goal 3: Bridge the gap between knowledge and practice			
ACCESS	FY 1993	FY 1999	FY 2000*
Homelessness Prevention	FY 1996	FY 1999	FY 2000

Supported Housing	FY 1997	FY 2000	FY 2001
HIV/AIDS Education I	Ongoing	Ongoing	FY 2000
HIV/AIDS Services Demo	FY 1994	FY 1998	FY 1999
AIDS High Risk	FY 1997	FY 2001	FY 2002
Employment (EIDP)	FY 1995	FY 2000	FY 2001*
Managed Care	FY 1996	FY 1999	FY 2000
KEN	FY 1995	Ongoing	FY 1999*
Community Action I	FY 1997	FY 1998	FY 1999*
Criminal Justice	FY 1997	FY 2000	FY 2001
Starting Early/SS	FY 1997	FY 2001	FY 2002
Consumer Services	FY 1998	FY 2002	FY 2003
Elderly Primary Care	FY 1998	FY 2002	FY 2002
Community Action II	FY 1998	FY 1999	FY 2000
Women and Violence	FY 1998	FY 2003	FY 2004
HIV/AIDS Outcome, Adherence	FY 1998	FY 2002	FY 2003
HIV/AIDS Education II	FY 1998	FY 2002	FY 2003
Native American Children	FY 1998	FY 2001	FY 2003

<u>New Activities</u>

Consumer & Supporter TA Centers	FY 1999	FY 2001
School-based Violence (Multi agency)	FY 1999	FY 2001
School-based Violence (Action Grants)	FY 1999	FY 2001
Alaska	FY 1999	FY 2000
Community Action Phase I	FY 1999	Ongoing
Homeless Families	FY 1999	FY 2004
Family & Consumer Network	FY 2000	Ongoing
HIV/AIDS Continuum of Care	FY 2000	FY 2003

2.19 Program Title: Community Mental Health Services Block Grant (Mental Health Block Grants) Annual Report of Ongoing Program

Performance Goals	*Targets*	*Actual Performance*	*Refer-ence*
Goal 1: Assure services availability			

1. SAMHSA Core Measures -Increase % of adults with serious mental illness who are employed. -Increase % of adults with serious mental illness who are living independently. -Decrease % of adults with serious mental illness who have had contact with the criminal justice system. - Increase % of children with serious emotional disturbance who attend school regularly. -Increase % of children with serious emotional disturbance who reside in a stable environment -Decrease % of children with serious emotional disturbance who have had contact with the juvenile justice system.	FY 01: TBD 3/01 FY 00: 17.5% FY 99: Establish baseline FY 01: TBD 3/01 FY 00: 66.7% FY 99: Establish baseline FY 01: TBD 3/01 FY 00: 5.3% FY 99: Establish baseline FY 01: TBD 3/01 FY 00: 65.8% FY 99: Establish Baseline FY 01: TBD 3/01 FY 00: 50.6% FY 99: Establish baseline FY 01: TBD 3/01 FY 00: 14.2% FY 99: Est. Baseline	FY 01: TBR 12/01 FY 00: TBR 12/00 FY 99: 17.3% Base* FY 01: TBR 12/01 FY 00: TBR 12/00 FY 99: 66.5% Base* FY 01: TBR 12/01 FY 00: TBR 12/00 FY 99: 5.4% Base* FY 01: TBR 12/01 FY 00: TBR 12/00 FY 99: 65.6% Base* FY 01: TBR 12/01 FY 00: TBR 12/00 FY 99: 50.4% Base* FY 01: TBR 12/01 FY 00: TBR 12/00 FY 99: 14.3% Base*	B61
2. States will pilot performance indicators	FY 01: Maintain FY 00: 16 States, 32 indicators FY 99: 16 States, 28 indicators	FY 01: TBR 8/1/01 FY 00: TBR 8/1/00 FY 99: 16 States, 32 Indicators FY 98 Baseline: 5 States, 28 Indicators	B61
Total Funding:	**1997: $275,420,000** **1998: $275,420,000** **1999: $288,816,000** **2000: $356,000,000** **2001 Req:$416,000,000**		

*Baselines for the six SAMHSA Outcome indicators were calculated by adding the numerators each state reported for each indicator and finding an average, the same calculation was made for the denominator. Once an average numerator and denominator was derived for each indicator the baseline percent was calculated.

2.19.1 Program Description, Content, and Summary of Performance

The goal of the Community Mental Health Services Block Grant is to assist the 59 eligible

and participating States and Territories in the planning and development of comprehensive community-based systems of care that will move the locus of care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) from costly and restrictive inpatient hospital care to the community where they can receive the necessary treatment and supports to live a more self-fulfilling and productive life. The mental health block grant (MHBG) is an impetus in encouraging states to develop community-based systems of care that can actually move to seriously reorganize and downsize the State psychiatric hospitals.

The Division of State and Community Systems Development DSCSD assists States in building their community-based systems of care. State-of-the-art technical assistance and consultation to State mental health agencies and mental health planning councils is provided through the National Technical Assistance Center for State Mental Health Planning (NTAC) to help ensure that best practices and up-to-date knowledge in mental health are translated into action at the State and local levels. During the first three years of NTAC, over 25 major publications were developed, 18 States received on-site technical assistance, and 13 regional and national technical assistance events were sponsored or co-sponsored by NTAC. According to a general survey conducted in the spring of 1998, technical assistance event satisfaction surveys, publication user feedback and survey responses, and periodic products and services status reports, all NTAC products were rated as "useful" to "very useful," (the highest rating). Feedback received on the web site and on technical assistance events also indicates a high level of satisfaction with NTAC products and services.

Set-aside monies have also made a significant investment in the development of the States' data infrastructure as they move toward the reporting of uniform outcome data. DSCSD and the State Mental Health Authorities through MHSIP (Mental Health Statistics Improvement Program) grants have collaborated around the specification and adoption of data standards for statistical systems. The managerial and research implications of MHSIP data emerge quite clearly when uniformity in their content permits the data to be compared across a number of settings.

In 1999, CMHS published definitions of serious mental illness (SMI) for adults and serious emotional disturbance (SED) for children which allowed CMHS and states to estimate the prevalence rate of adults with SMI and children with SED by State. For the first time, there are now prevalence rates by State for adults with SMI and this laid the groundwork for the Five-State Feasibility Study, a landmark joint State-Federal initiative to compile similar performance and outcome indicators on public mental health systems from multiple States. The goal development effort was to determine whether the States would be able to move toward increased commonality of reporting within and among States. The results of this feasibility study clearly demonstrated the potential for developing comparable measures across States and the ability to report uniform data on a national basis. The Sixteen State Indicator Pilot Grants builds on the work of the Five State Feasibility Study. The purpose of these grants is to have the 16 States use common definitions in implementing all 32 performance indicators over the three year grant period. In an effort to further promote the collection of data and the movement of States

to performance indicators and outcome measures, DSCSD provided the States in its FY 1999 application a menu of illustrative performance indicators and outcome measures for States to use in the development of their State mental health plans. This menu was a precursor to the 28 indicators studied in the Five State Feasibility Study which were later refined by the National Association of State Mental Health Program Directors (NASMHPD) President's Task Force on Performance Indicators. In addition to the menu offered the States, the application also requests the States to report on the six SAMHSA core outcome measures.

With the focus on development of community-based systems of care, the expectation was that the State hospital infrastructure would undergo a significant redesign. From 1970 to 1994 the number of State psychiatric hospital beds declined dramatically--a decrease of over 400%. While downsizing of facilities is an important component of the process in moving the locus of care, it is not as significant as when the actual infrastructure changes occur, such as the closure of hospitals and the movement to the use of community facilities. So while the number of beds decreased, the number of hospital closures from 1970 to 1990 was only 14 (277 to 263). On the other hand, from 1990 to 1996 a total of 34 State psychiatric hospitals were closed. It is anticipated that these kinds of movements will continue. States have reported that they are continuing to further reorganize and downsize their systems and 116 of the 231 State psychiatric hospitals over the next several years will be affected.

The progress made in moving the locus of care is further demonstrated with the use of financial data. In FY 1981, the heavy reliance of States' use of State psychiatric hospitals is reflected by the fact that 63% of the expenditures controlled by the State Mental Health Agencies were allocated to the State psychiatric hospitals, with only 33% of the total resources being used for community-based services. By FY 1993, the expenditures of the community-based service system had increased to 49%, the same amount as the State psychiatric hospitals. In 1997 State spending for community-based services increased to 56% of the State Mental Health Agency budget while State psychiatric hospital expenditures equaled only 41%. It is expected that this trend will continue for States have instituted a number of strategies to continue the realignment of the infrastructure. For example, currently, 29 States have community-based gate keeping systems in place that regulate access to the State psychiatric hospitals and in 13 States community mental health programs receive financial incentives to reduce State psychiatric hospital utilization.

As States have grappled with the difficulties associated with such tremendous change in their infrastructures and the corresponding shifts of resources, there is still much work that needs to be done to ensure that each State actually develops a comprehensive community-based system of care for adults with SMI and children with SED. From FY 1981 to FY 1997 State Mental Health Agency's budgets when adjusted for inflation actually declined by 7.0%. Because of this decline in the availability of resources, States have been unable to treat all persons in need of care and do not conduct aggressive outreach activities even though there is considerable evidence to demonstrate that there are many persons in need of care who are not receiving it. Further, there

are serious gaps in service for those who are in treatment. For community-based systems to work there must be an array of support services in place to help the person be able to function in the community. Almost all States are now challenged in filling gaps around the need for housing in general and appropriate housing in particular; job and work opportunities for the targeted population; and other support services that are not reimbursed or funded because they are not considered medically necessary.

While there has been considerable work in the collection of data it is necessary to continue building data and other infrastructures that will combine the State Hospital system with the community-based system and respond to the new challenge for accountability to demonstrate that the systems in place are efficient and effective. The 16-State Pilot Indicator Project and other efforts are in place to move the States to a uniform national data system. It is significant that for the first time there is, through the 16 State Indicator Pilot Project comparable data available across the 16 States, on the unduplicated count of people served in State Psychiatric Hospitals. Nevertheless, currently there are only 27 States that have a system that will permit the tracking of clients between the State hospital and the community for an unduplicated count. DSCSD is committed to moving all States to the development of performance and outcome measures to demonstrate their efficiency and effectiveness. We do know that there is movement in this area which will continue. For example 15 States use outcome measures in performance contracting, 17 States fund consumer initiatives to monitor satisfaction, and 22 States are involved in developing a mental health report card. It is clear however that work does need to continue, for only three States are currently measuring the quality of life of consumers.

Comments on Measures: Over the past several years, DSCSD has collaborated with the States in the development of performance indicators. Two strategies have been pursued. First, a set of measures was approved by OMB for implementation on a voluntary basis as part of the FY 1999 MHBG application package. The full array of performance indicators contained in the mental health block grant application is included in Appendix B.5. The application also includes the six SAMHSA core measures identified in measure #1 and supported as very important measures by CMHS. Per OMB instructions, the States were requested, but not required, to report on their ability to provide data on the six SAMHSA Core outcome measures in their FY 1999 Implementation Reports that were due on December 1, 1999.

Second, more intensive work was initiated first with five states to test the feasibility of 28 indicators, and later with 16 States to test and pilot the 32 NASMHPD indicators. This work is intended to expand the capacity of the States to report uniform data on similar performance measures. Measure 2 reflects the implementation of this three year Performance Indicator Pilot program to expand State infrastructure capacity.

Initial results are reported below on these two major strategies: the initial voluntary collection of outcome data as part of the mental health block grant application, and the16-State Performance Indicator Pilot project.

2.19.2 Goal-by-Goal Presentation of Performance

As previously indicated, per OMB instruction, the States were requested to voluntarily report on the SAMHSA six core measures in the FY 1999 Implementation Report. If they were unable to provide actual data on the measures they were asked to comment on their ability/inability to do so in the future. Twenty-seven States, or 54% did not report on the core measures or were unable to provide data on them. A total of 46% (23) of the States provided data on one or more of the core measures. Three of the States, or 6%, reported on all 6 of the core measures, however only 16% of the States were able to report on 4 or more of them. The largest number of States (9) reported data on two of the six core measures. The following chart indicates the number of States reporting on each measure and the baseline that was developed from the submitted data.

Performance Goals: Performance goals for this program address Goal 1 "Assure services availability." Measures focus on two major dimensions of this goal: improving service outcomes and improving the ability of states to measure systems performance.

Measure 1: Core Measures for Adults and Children:

Adults
Increase the percent of adults with SMI who are employed.
Increase the percent of adults with SMI living independently
Decrease the percent of adults with SMI who have had contact with the criminal justice system.

Children
Increase the percent of children with SED who attend school regularly.
Increase the percent of children with SED who reside in a stable environment.
Decrease the percent of children with SED who have had contact with the juvenile justice system.

Rationale: These outcome measures are critical to reflect the community adjustment of adults with serious mental illness and children with serious emotional disturbance. They are also core outcome measures for SAMHSA's discretionary programs. These measures help to measure some important aspects of program performance.

Data Source and Validity of Data: The data source is the FY 1999 Implementation Reports submitted to CMHS on December 1, 1999. The States vary in their data collection capability so many States, which would like to report the data did not do so because they lack the necessary infrastructure to generate the data. Further, because the reporting of the data is voluntary, many States chose not to respond as indicated in the table below. Since the current application will remain voluntary until the

year 2001 it is very likely that many States will continue to not respond and if they responded for FY 1999 there is no guarantee or requirement that they will provide data for FY 2000 or beyond. The voluntary application package also did not permit any specificity as to what was to be measured so the States are interpreting the SAMHSA Core measures using their own definitions and in some cases are using proxy measures in place of the core measures. All of these circumstances contribute to the conclusion that minimal data will be collected from the States and what is collected will not be uniform. Further, there is no guarantee that the data will be consistent or reliable. While the baseline is an average of what the States submitted, there is significant variation among the States in the data reported as can be seen in the following table.

Variation Among the Data Reported

Children's Measures

Performance Indicator	Lowest State	Highest State
Children with SED who attend school regularly	17%	90%
Children with SED who reside in a stable environment	28%	82%
Children with SED who have had contact with the juvenile justice system	1%	48%

Adult Measures

Performance Indicator	Lowest State	Highest State
Adults with SMI who are employed	8%	45%
Adults with SMI who are living independently	17%	88%
Adults with SMI who have had contact with the criminal justice system.	8%	13%

The cause of this variation is unclear, however, it is likely to be related to the fact that the voluntary application did not permit the inclusion of uniform or standardized definitions of what was to be measured so each State is using their own definition.

Baseline: From FY 1999 State Implementation Reports:

Children's Measures

Performance Indicator	States Reporting	Baseline
Children with SED who attend school regularly	9	65.6%
Children with SED who reside in a stable environment	6	50.4%
Children with SED who have had contact with the juvenile justice system	11	14.3%

Adult Measures

Performance Indicator	States Reporting	Baseline

Adults with SMI who are employed		17	17.3%
Adults with SMI who are living independently	16	66.5%	
Adults with SMI who have had contact with the criminal justice system	11	5.4%	

As reported above, the indicator most frequently reported by the States was adult employment with 17 States supplying data. The indicator least likely to be reported, with 6 States responding, was children living in a stable environment. Overall, the response rate regarding the voluntary request for this data is extremely low and the baseline for the 6 indicators in fact reflects a range of only 12% to 34% of the States.

Target: See table 2.19 for the multiple listing of targets.

Progress Update: Twenty-three States reported data on one or more of the six core outcome measures in their FY 1999 Implementation Reports. A FY 1999 baseline for each of the 6 core measures was calculated using the States' data and a reasonable target developed for FY 2000.

Measure 2: States will pilot performance indicators between FY 1998 - FY 2001.

Rationale: In the FY 1999 pilot, sixteen states began piloting 32 performance measures State wide. By the end of FY 2001, this pilot work will be completed. The Sixteen State Indicator Pilot Grants build on the work of the Five State Feasibility Study which identified 28 performance measures. The 28 measures were later refined by NASMHPD into 32.

Data Source and Validity of Data: The Five State Feasibility Study documented the feasibility of piloting a common set of performance indicators using common definitions in a comparable way across States. The purpose of the pilot project is to work further with the performance indicators and assess the validity of the data collected as the performance measures are implemented.

Baseline: Baseline performance data for the 16 states on all of the indicators will be available in FY 2002. Targets will be developed once baseline data are available.

Target: FY 2000 and FY 2001, 16 States, 32 indicators.

Progress Update: CMHS awarded State Indicator Pilot grants to16 State Mental Health Authorities in the FY l999 fiscal year. These State grant projects were funded for a three year period and are focusing on the piloting of 32 performance indicators that were recommended in the l997 CMHS Five State Feasibility Study and the l999 NASMHPD Framework of Mental Health Performance Indicators. It is expected that States will be able to implement these selected indicators on a Statewide basis by the end of the grant period.

The 16 grantee States have been meeting regularly, and data collection for 9 indicators has been initiated. These 9 include the previously mentioned penetration/utilization rates for hospitalization, level of functioning and symptoms, use of assertive community treatment services, use of supported employment services, and use of atypical medications.

In Year 2 of the project, additional performance indicators will be tested. A subset will be further developed, and six indicators will be worked on in coordination with a State outcomes initiative being undertaken by the National Association of State Mental Health Program Directors (NASMHPD).

In the FY 1998 Pilot, sixteen States began piloting the 32 National Association of Mental Health Program Directors (NASMHPD) Framework of Mental Health Performance Indicators. It is expected that these States will be able to implement these selected indicators on a Statewide basis by the end of the three year grant period. To report information a national and uniform basis it is important to report on common indicators across systems to determine comparability Therefore, a major activity of the 16 State Indicator Pilot Project is for the States to develop and agree to comparable definitions in the proposed data collection activities of this project. The first area selected for development of comparable definitions was penetration/utilization rates for State hospital inpatient services. State psychiatric hospitals as the traditional locus of care tend to be more sophisticated regarding their data collection efforts. In addition, hospital data can be very informative regarding utilization patterns and whether States are in fact shifting the locus of care from the hospital to the community.

The following represents actual uniform data reported for the 16 State Indicator Pilot Grantees in hospital penetration rates.

HOSPITAL PENETRATION RATES

State	Unduplicated Count Of People Served in State Psychiatric Hospitals	Total State Population	People Served per 100,000 Population
	#		
Arizona	572	4,554,966	13
Colorado	4,316	3,892,644	111
Connecticut	2,352	3,269,858	72
D.C.	2,706	528,964	512
Illinois	7,294	11,895,849	61
Indiana	2,498	5,864,108	43
Missouri	7,799	5,402,058	144
New York	13,726	18,137,226	76
Oklahoma	3,158	3,317,091	95

Rhode Island		165		987,429	17
South Carolina	7,741		3,760,181	206	
Texas		13,102		19,439,337	67
Utah		751		2,059,148	36
Virginia	7,950		6,733,996	118	
Vermont		324		588,978	55
Washington		3,701		5,610362	66

Penetration/utilization rates provide a basic and powerful measure of the amount of access to care in a geographical region. This indicator of access to care is produced by directly measuring the number of duplicated people who use specified services in an area, and comparing this utilization to the size of the population as a whole (also used in comparisons by age, gender, and race/ethnic groups). It should be noted that State psychiatric hospitals do not represent the totality of inpatient psychiatric care that is available to people in need. In many States, the State mental health authority contracts directly for inpatient care through other facilities, such as general hospitals, private psychiatric hospitals, and veterans hospitals, among others. In order to obtain a fuller profile of behavioral health care penetration/utilization rates, unduplicated utilization of these service sectors is being addressed at this time. The measurement of penetration/utilization rates also will be expanded in the next year to include community-based programs.

Data has also been collected for nine of the sixteen States in the area of consumer satisfaction which is presented in the table below. The major goal of mental health services is to achieve positive outcomes for consumers. While improvement can be measured through the use of clinical instruments, it is critical to assess outcomes from the perspective of the consumer. The data in the following table represent survey results from the use of consumer surveys in 9 of the 16 State Mental Health Agencies (SMHA) participating in the 16 State Pilot Project. As such, they represent a reflection of the consumer point of view with respect to care. One thing to be noted in the table, is that the key dimensions of quality are covered: including access to care, appropriateness/quality of care, outcomes of care and participation in the planning of care. It is clear that variability exists among States in how consumers perceive the care delivered to them. Such data can be very useful in identifying situations where further study is needed and assist in identifying variables that to determine why perceptions differ. States are not identified in this initial reporting of results because sufficient analysis of the reasons for variability in results has not yet occurred.

Mental Health Statistics Improvement Program

CONSUMER SURVEY-ADULT OUTPATIENTS

State	N	Percent of Consumers	Percent of Consumers	Percent of Consumers Reporting Positive	Percent of Consumers

		Agreeing Access was Appropriate	Agreeing with Appropriateness/Quality Items	Treatment Outcomes	Reporting Participation in Treatment Planning
1	1167	68.3%	73.8%	57.3%	
2	1200	78.2%	75.7%	66.2%	64.5%
3	245	74.7%	79.7%	73.0%	55.4%
4	288	83.3%	79.7%	79.1%	
5	562	91.8%	93.0%	72.0%	
6	719	91.1%	88.3%	70.2%	74.5%
7	306	76.5%	73.4%	60.7%	
8	2204	85.4%	83.2%		73.4%
9	1170	74.3%	72.6%		
Overall Mean		78.7%	79.4%	66.1%	69.1%
Confidence Interval		77.9% - 79.5%	78.9% - 80.4%	64.8% - 67.4%	67.9% - 70.4%

State 1 – Medicaid Managed-Care regional authorities conducted mail survey
State 2 – SMHA conducted survey of statewide sample- mail and consumer-administered
State 3 – SMHA conducted consumer-administered survey at 3 sites
State 4 – SMHA surveyed all consumers presenting for services during a one week period at one site. Staff handed out survey, drop boxes in waiting area.
State 5 – SMHA surveyed all consumers presenting for services during a one week period. Staff handed out survey, return mail.
State 6 – SMHA surveyed all consumers presenting for services during a one week period. Staff handed out survey, drop boxes in waiting area.
State 7 – SMHA conducted mail survey of random sample
State 8 – SMHA surveyed all consumers presenting for services during a one week period. Staff handed out survey, drop boxes in waiting area. State 9- SMHA conducted statewide mail survey of all Medicaid consumers

2.20 Program Title: Protection and Advocacy for Individuals with Mental Illness (PAIMI) (Services Formula Grants) Annual Report of Ongoing Program

Performance Goals	*Targets*	*Actual Performance*	*Reference*
Goal 1: Assure services availability			
1. Increase the number of complaints of abuse that will be addressed.	FY 01: 11,100 FY 00: 9650 FY 99: 9000 (FY 00 target revised upward)	FY 01: TBR 3/02 FY 00: TBR 3/01 FY 99: TBR 3/00 FY 98: 8,687 FY 97 Baseline: 8,360	B52

2. Maintain the number attending education, training, public awareness activities	FY 01: 320,000 (Was 200,000) FY 00: 290,000 (Was 160,000) FY 99: 260,000 (FY 00 and FY 01Target revised upward)	FY 01: TBR 3/01 FY 00: TBR 3/00 FY 99: TBR 3/00 FY 98: 230,343 FY 97 Baseline: 150,916	B52
3. Maintain % of priorities and goals that were achieved or made substantial progress	FY 01: Maintain at 85% FY 00: Increase to 85% FY 99: Maintain at 70% (Target revised upward)	FY 01: TBR 3/02 FY 00: TBR 3/01 FY 99: TBR 3/00 FY 98: 83% FY 97 Baseline: 70%	B452
4. Increase substantiated incidents of abuse, neglect or rights violations reported to State P&A systems which are favorably resolved. [note: change in language, see narrative]	FY 01: TBD 3/01 FY 00: TBD 3/01 FY 99: N.A.	FY 01: TBR 3/02 FY 00: TBR 3/01 FY 99: Baseline: TBR 3/00	B52
Total Funding: (N.A.)	**2001: Req. $ 25,903, 000** **2000: $24,903,000** **1999: $22,949,000** **1998: $21,957,000** **1997: $21,957,000**		

2.20.1 Program Description Context and Summary of Performance

The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act of 1986 [42 U.S.C. 10801 et seq.] extended the protections of the Developmental Disabilities and Bill of Rights Act (the DD Act) by creating a program to ensure protection and advocacy for individuals with mental illness who are at risk of abuse or neglect while receiving care or treatment in public and private residential facilities, e.g., hospital, foster home, group home, homeless shelter, prison/jail, juvenile detention center, nursing home, etc.**,** and to enforce the Constitution, Federal and State laws. The Center for Mental Health Services (CMHS) administers the PAIMI Program formula grant awards to the 50 States, the District of Columbia, and 5 Territories. These awards are based on per capita income and population. The awards range from a minimum of $ 145,584 to the 5 Territories, to $2 million to California, the largest State. The PAIMI Funds are used by the protection and advocacy (P&A) system designated by the Governor (Mayor in D.C.) for the following purposes:

> To investigate incidents of abuse and neglect in public and private residential care and treatment facilities and to pursue administrative,

legal (individual and class action litigation), systemic and legislative activities, and other appropriate remedies that will redress complaints of abuse, neglect and rights violations on behalf of individuals with mental illness in residential facilities.

Context: The designated system is responsible for determining those priority activities for which PAIMI funds are expended. The State P&A systems funded by CMHS identify incidents of abuse, neglect and rights violations in public and private residential care treatment facilities and investigate these incidents. State P&A systems also develop and implement public education and training programs focused on ensuring that the Constitutional, Federal and State rights of individuals with mental illness are protected.

Summary of Performance: Each eligible State P&A system that receives CMHS PAIMI grant funds is required to submit an annual program performance report (PPR) on or before January 1. This annual report is a summary of the State P&A system's priorities and activities for the previous year and by law includes the following information: descriptions of State P&A system activities and statements on the PAIMI program priorities, objectives, accomplishments and expenditures for the previous fiscal year. FY 1999 PPR information from the States will be used to report FY 99 PAIMI performance information. Examples of services provided by State P&A systems in FY 1998 are highlighted in Measure 1. The P&A systems have succeeded in expanding their services to clients in FY'97 and '98. For example:

FY	Clients Served	Complaints Addressed
1997	15,658	23,356
1998	15,898	25,527

Comments on Measures: PAIMI Program performance goals address Goal 1 - to assure the availability of services. Measures are focused on system productivity, the number of abuse complaints addressed, and the number of individuals attending P&A system-sponsored activities. The number of clients served was narrowed to focus on the number of abuse complaints addressed. These measures were developed through an interagency effort [Administration on Developmental Disabilities (HHS/ADD), the Department of Education, Rehabilitation Services Administration (RSA), and the Center for Mental Health Services]. The measures are also used by ACF and RSA to administer their respective protection and advocacy program activities. These PAIMI measures will also be used in subsequent years. PAIMI data-sources for all measures are the Annual Program Performance Report (PPR) and the Advisory Council (AC) Reports submitted by each of the 56 P&A systems, as required by the PAIMI Act. The information provided in these annual reports is generally reliable. P&A system

activity information for FY 1999 will not available until approximately 3/15/00 and FY 2000 until 3/15/01.

2.20.2 Goal by Goal Presentation of Performance

Performance Goals: This program addresses Goal-1, "Assure Service Availability". Performance measures number served by P&A system sponsored activities and the number of complaints addressed.

Measure 1: Increase the number of complaints of abuse that will be addressed by State PAIMI systems.

Rationale: Of the 25,527 abuse, neglect, and rights violation complaints addressed by the State P&A programs in FY 98, the number of incidents involving abuse increased to 8,687 (FY 97: 8,360). The majority of these incidents involved failure to provide mental health treatment (25%), physical assault (12%), inappropriate or excessive restraint/seclusion (12%), failure to provide medical treatment (10%), and inappropriate or excessive medication (11%). There were also numerous fatalities involving individuals with mental illness who received care or treatment in a residential facility at the time. State P&A systems conducted investigations of these highly publicized deaths and issued findings which substantiated that residential facility staff either used excessive physical restraint or provided inadequate medical care.

Baseline: FY 1997 baseline and targets is established at 8,360 incidents.

Data Source and Validity of Data: The information provided in these annual reports is cross checked for reliability during on-site visits to funded programs.

Target: For FY 2000, 9650 abuse complaints addressed. For FY 2001, 11,100 complaints addressed.

Progress Update: Progress was made toward the FY 99 target.

Case examples of abuse complaints in which PAIMI intervention was required:

(1) This State P&A system decreased incidents of abuse and neglect in a State residential treatment facility through increased monitoring. The facility treated 35 boys and girls, aged 8-17 years, from two contiguous States who were placed by their respective states because of "trouble with the law." PAIMI staff, while conducting an outreach visit at the facility, asked a little girl about the numerous scratches on her arms and legs. She said "they took me down." The child explained that facility staff "slammed" her against the floor, against the wall or against whatever object was nearby.

Other children also explained to PAIMI staff how the facility was managed. PAIMI staff conducted training for facility staff on the rights of residents. However, the training was not well received by facility staff who became upset, told PAIMI staff that "you can't take away our power," and then disrupted the training session. The children, when provided with patients' right training, thought the PAIMI staff was joking as they thought they had no rights and that it was acceptable for facility staff to physically punish them. PAIMI staff made numerous repeat visits to interview the children who continued to relay incidents of abusive treatment by facility staff.

The PAIMI staff reported these findings to the State (which licensed the facility) Office of Children's Services (OCS), the children's legal custodians. However, OCS made no effort to remedy the situation, PAIMI staff requested that the State's Department of Social Services (DSS) investigate the facility. The DSS investigation resulted in OCS removal of the children, placement in a more appropriate treatment setting, and termination of the facilities license to operate. This facility no longer exists.

(2) In one State, PAIMI Program staff investigations found an adolescent, an inpatient of an adolescent psychiatric unit, who identified her rapist - a hospital health aide. The case was prosecuted and the aide sentenced to a correctional facility. The State police investigation, initiated after a PAIMI Program attorney reported the rape, led to three other female adolescents on this unit, whom the aide had also sexually assaulted. During the course of these investigations, PAIMI staff insisted that the Department of Mental Health (DMS), which funded the hospital's adolescent unit, increase its oversight of the facility and ensure that allegations of assault on residents are reported and thoroughly investigated. DMS responded to the PAIMI staff concerns by taking appropriate action.

(3) The death of a 16-year-old male, under treatment in a private psychiatric hospital, led to a PAIMI investigation and captured the attention of *60 Minutes,* a CBS-TV news magazine, which televised the incident in an April 1998 expose on abuses at private psychiatric hospitals for children and adolescents. On March 4, 1998, a young man was admitted to the hospital in a severe state of depression. After barricading himself in his room, six hospital staff gained entry, placed the youth in "therapeutic" holds, and prepared to carry him to a seclusion room. Staff covered the youth's face with a towel and a sheet because he spat at them. During his transport to the seclusion room, the patient was held face down, with a staff person holding each arm and leg while one staff person supported his head. When staff lifted the youth, he stopped struggling and was heard to state "you're choking me," before becoming silent; he had suffocated.

The P&A conducted an investigation which found numerous staff violations, such as, state failure to monitor the patient throughout this restrictive intervention process. The use of the towel and the sheet may have contributed to his death. Subsequent investigation by the local

police department resulted in a grand jury indictment of one hospital employee. Six hospital employees await a decision on whether they too will also be indicted.

Measure 2: Increase the number of individuals attending public education and/or constituency training activities and public awareness activities offered by the PAIMI programs.

Rationale: Expansion of State P&A system outreach services, the provision of advocacy training to individuals with mental illness and their family members, and distribution of general information on various topics, i.e., disability rights, consumer self-advocacy, the PAIMI Act, and State P&A systems, will increase public awareness and general understanding of the availability of P&A system services to PAIMI eligible individuals and their family members. Information on P&A system activities for FY 1999 will be available by approximately 3/00, and FY 00 until 3/01.

Data Source and Validity of Data: The information provided in these annual reports is cross checked for reliability during on site visits to funded programs.

Baseline: Established at 150,916 based on FY 1997 reporting.

Target: FY 2000, 290,000 attending education, training, public awareness activities. For 2001, 320,000.

Progress Update: The FY 1998 data showed a substantial progress toward the FY 1999 target. FY 1999 actual data will be reported in 3/00. On the basis of data available ensuing targets have been revised upward.

Measure 3: Increase the percentage of priorities and goals assessed by the PAIMI Advisory Council to have made substantial progress or to have been achieved.

Rationale: This measure provides an assessment of PAIMI program performance and accomplishment of goals and objectives in the 56 P&A systems- it is focused on the core outcomes.

Data Source and Validity of Data: See "Comments on Measures" Data source: Annual Program Performance Reports (PPR) from the State P&A's.

Baseline: Approximately 80 percent of the PAIMI priorities and goals were achieved or made substantial progress in FY 1998 over the baseline set in FY 1997.

Target: FY 2000: Increase to 85%, FY 2001: Maintain at 85%, the % of priorities and goals that were achieved or made substantial progress.

Progress Update: FY 99 target was achieved in FY 98, therefore the baseline was increased to 85 percent for FY 2000.

Measure 4: Increase the substantiated incidents of abuse, neglect, or rights violations reported to State P&A systems that are favorably resolved.

Rationale: This measure will assess the performance outcome of the State P&A systems' program activities that focus on favorable resolution of complaints from individuals. PAIMI clients, due to their individual situations, e.g., incapacity, fatality, etc., are often unable to report these incidents. Family members, legal guardians, conservators, anyone may report an incident to the State P&A system, which will conduct an investigation to determine whether the alleged abusive incident is substantiated.

Data Source and Validity of Data: Annual Program Performance Reports (PPR) from the State P&A's.

Baseline: To be reported when data is collected.

Target: To be set after the baseline is determined, 3/2000.

Progress Update: After FY 1999 baseline data is available in 5/00, FY 2000 and FY 2001 targets will be established.

2.21 Program Title: Projects for Assistance in Transition from Homelessness (PATH)

Performance Goals *Goal 1: Assure services availability*	*Targets*	*Actual Performance*	*Refer-ence*
1. Increase the number of persons contacted.	FY 01: 118,000 FY 00: 109,000 FY 99: 102,000 *	FY 01: TBR 6/03 FY 00: TBR 6/02 FY 99: TBR 6/01 FY 98: TBR 6/00 FY 97: 104,000 FY 96 Baseline: 105,00	B57
2. Increase % of participating agencies that offer outreach services	FY 01: Maintain at 80% FY 00: 80% FY 99: 70%*	FY 01: TBR 6/03 FY 00: TBR 6/02 FY 99: TBR 6/01 FY 98: TBR 6/00 FY 97: 87% FY 96 Baseline: 84%	B57

3. Maintain % of persons contacted who become enrolled clients at 33% or greater	FY 01: Maintain at 33% FY 00: 33% FY 99: 30% *	FY 01: TBR 6/03 FY 00: TBR 6/02 FY 99: TBR 6/01 FY 98: TBR 6/00 FY 97: 41% FY 96: Baseline: 41%	B57
Total Funding:	**1997: $20,000,000** **1998: $23,000,000** **1999: $25,991,000** **2000: $30,883,000** **2001 Req:$35,883,000**		

*Note: See explanation of FY 1999 performance on page 133.

2.21.1 Program Description, Content, and Summary of Performance

The Projects for Assistance in Transition for the Homeless (PATH) program is a formula grant to States to provide services to homeless persons with serious mental illness. The goal of this program is to provide services that will enable persons who are homeless and have serious mental illness to be placed in appropriate housing situations and to engage them with formal mental health treatment and systems so as to improve their mental health functioning.

PATH programs have been successful in targeting assistance to persons who have the most serious impairments. Among all enrolled clients who received PATH services in 1997, 43% had schizophrenia and other psychotic disorders. Another 35% had affective disorders, including severe depression and bipolar disorder. At least 59% had co-occurring serious mental illnesses and substance abuse disorders. At the time of first contact with providers, 55% of all clients living in the streets, in shelters or in temporary housing had been homeless for more than 30 days. Despite the fact that they have multiple and complex needs are difficult to reach, 41% of the homeless individuals contacted through PATH-funded outreach became enrolled.

2.21.2 Goal-by-Goal Presentation of Performance

Performance Goals: This program addresses Goal-1, "Assure Service Availability". Performance measures numbers served by outreach activities and increasing the availability of outreach services.

Measure 1: Increase the number of persons contacted

Rationale: The number of persons a PATH funded provider contacts is a measure of impact.

Data Source and Validity of Data: The quality of the data on the number of persons contacted varies. A person contacted is someone, not necessarily a PATH client, who meets with a PATH funded staff person providing outreach services. Some persons contacted are not willing to accept other services during the reporting period; others are not eligible, usually because they do not have a serious mental

illness. To improve the quality of the data, PATH has adopted quality control measures expected to further improve data collection and reporting.

Baseline: Baseline: 105,000. See paragraph 2 of 2.1.1 in program description.

Target: Increase the persons contacted by: FY 00: 109,000, FY 01: 118,000.

Progress Update: The PATH program experienced a 32 percent decrease of funding from $29.6 million in FY 1995 to $20 million in FY 1996. Because most States award their annual PATH funds late in the fiscal year, the FY 1996 budget decrease did not have its full impact until 1997. The proposed FY 2001 budget increase would enable PATH funded programs to contact 118,000 persons, 9,000 more than the estimate for FY 2001. Because the funding increase actually reaches programs late in each fiscal year, the effect of the FY 2001 budget increase will primarily impact performance during FY 2002, which will be reported in FY 2003. Please note that annual targets or performance data in the table refer to the impact during the fiscal year following the appropriation year indicated in the chart.

Measure 2: Increase the percentage of participating agencies offering outreach services

Rationale: Outreach is the most frequently provided PATH-funded service. CMHS will encourage States to increase their funding for outreach services. The strategy of using PATH funds to connect the eligible population with existing, rather than additional community resources, continues to be important. The challenge for local providers will be to maintain outreach services at close to current levels rather than offer later stage services whose availability may have decreased as a result of reduced resources in affiliated non-PATH programs. A $35.9 million appropriation will enable the percentage of participating agencies offering outreach services to be maintained at the 80 percent level.

Baseline: 84 percent

Target: Increase the percentage of participating agencies offering outreach services, for FY 2000: 80%, for FY 2001: maintain at 80%.

Data Source and Validity of Data: The source of the information is data that States submit annually to CMHS. The sources of the State data are the local agencies that provide the services. In an effort to ensure the quality of the data, CMHS identified local agencies that reported data outside expected ranges, and based on discussions with these providers and their respective State PATH Contacts, has improved the accuracy of the 1997 data. CMHS has developed additional error checks and has contacted States concerning the accuracy of data outside expected ranges. CMHS has also issued guidance to all States and localities on data collection and has held a series of telephone conference calls with local providers to discuss key issues pertaining to the accuracy of PATH related data. CMHS has also monitored compliance with data collection through site visits to local PATH funded agencies.

Progress Update: Because of the two year time lag in obtaining data that reflect any given appropriation year, FY 1999 performance data will become available in June 2001. FY 2000 data will become available in 2002. FY 2001 data will become available in June 2003.

Measure 3: Increase the percentage of persons contacted who become enrolled clients.

Rationale: Most local PATH funded agencies provide outreach services. In fact, PATH funds are often the only monies available to communities to support outreach to, and engagement of, clients and their transition to mainstream services. The process of outreach requires skill in gaining the trust of persons who, in many cases, are reluctant to accept help.

However, not all persons contacted, even those willing to accept help, were eligible for PATH-funded services. In many cases, as mentioned above, it may have turned out that the person contacted, after further assessment, did not have a serious mental illness. In these cases, the person was assisted by the PATH-funded agency, but through services funded by non-PATH sources, or was referred to another agency.

A $30.9 million appropriation in FY 2000 will enable PATH funded programs to enroll at least 33 percent, rather than the previous minimum of 30 percent, of persons contacted. However, as previously explained the effects of program performance in FY 2001 will be most evident in FY 2001 program performance, not reported until 2002.

Data Source and Validity of Data: The sources of the data are States which receive these data from local providers. As mentioned above, CMHS has introduced additional error checks and will be issuing new guidance to States expected to further upgrade the accuracy of the data.

Baseline: 36 percent, FY 1996

Target: For FY 2000: 33%, for FY 2001: Maintain at 33%.

Progress Update: In FY 1997, PATH providers successfully enrolled 41 percent of persons contacted as clients. In most cases, they provided for, or arranged to meet immediate needs of clients, often found temporary or longer term shelter and arranged for mental health treatment.

Case Example: The effectiveness of PATH funded services is evident in the example of Karen, a homeless person with serious depression, a panic disorder and a substance use disorder. Staff of the local PATH funded provider helped her obtain shelter, mental health treatment, legal aid, and social security benefits. After several months, Karen was living in a furnished apartment, taking prescribed medication, and working full time.

2.22 Program Title: Comprehensive Community Mental Health Services for Children and Their Families (Targeted Capacity Expansion) Annual Report of Ongoing Program

Performance Goals *Goal 2: Meet emerging and unmet needs*	*Targets*	*Actual Performance*	*Refer-ence*

1. Increase Interagency collaboration: -Referrals from non-MH agencies for MH services will increase	FY 01: Maintain at 10% FY 00: Maintain at 10% FY 99: 10% increase	FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99: Referrals from non-MH 80.1% (7.3% increase) FY 98: Referrals from non-MH 79.7% (6% increase) FY 97: Baseline: 75%	B49
-Referrals from juvenile justice programs will increase	FY 01: 20% increase FY 00: Maintain at 12% FY 99: 12% increase (FY 01 Target revised upward based on FY 98 performance)	FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99: Referrals from juvenile justice 22.5% (150% increase) FY 98: Referrals from juvenile justice 18.2% (102% increase) FY 97 Baseline: 9%	
-Case records that reflect cross-agency treatment planning will increase.	FY 01: 50% increase (Was 10%) FY 00: Maintain at 10% FY 99: 10% increase (FY 01 Target revised upward based on FY 98 performance)	FY 01: TBR 8/01 FY 00: TBR 08/00 FY 99: Cross-agency planning: 58% (45% increase FY 98: Cross-agency planning: 48.9% (22% increase) FY 97 Baseline: 40%	
2. Decrease utilization of inpatient/residential treatment (avg days in facility)	FY 01: 40% decrease (Was 20%) FY 00: Maintain 20% decrease FY 99: 20% decrease FY 01: Target revised upward based on FY 98 performance)	FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99: At 12 months, 144 days (44% reduction) FY 98: At 12 months, 143.3 days (45% reduction) FY 97 Baseline: 265 days	B49

3. Children's outcomes: -Increase the percent of children attending school 75% or more of the time -Increase the percent of children with law enforcement contacts at entry who have no law enforcement contacts after 6 months.	FY 01: 25% increase FY 00: Maintain at 10% FY 99: 10% increase (FY 01 Target revised upward based on FY 99 performance) FY 01: Maintain at 57% FY 00: Maintain at 57% FY 99: 57% (10% increase)	FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99: 88.9% attending at 12 months (27% increase) FY 98: 78.8% attending at 12 months (12% increase) FY 97 Baseline: 70% FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99: 43% with no law enforcement contacts at 12 months (4% decrease) FY 98: 54.8% with no law enforcement contacts at 12 months (7.8% increase) FY 97 Baseline: 47%	B49
4. Increase level of family satisfaction with services	FY 01/00: Maintain at 10% FY 00: Maintain at 10% FY 99: 10% increase FY 98: 5% increase	FY 01: TBR 8/01 FY 00: TBR 8/00 FY 99: 88.9% satisfied at 12 months, (27% increase) FY 98: 74.7% satisfied at 12 months (6% increase) FY 97 Baseline: 70%	B49
5. Increase stability of living arrangements by decreasing the percent of children having more than one living arrangement after 6 months in services	FY 01: 65% decrease (Was 20%) FY 00: 25% decrease FY 99: 20% decrease (FY 01 Target revised upward based on FY 98 performance)	FY 01: TBR: 8/01 FY 00: TBR: 8/00 FY 99: At 12 months, 27% (64.5% decrease from baseline) FY 1998: At 12 months, 23.7% (69% decrease from baseline) FY 97 Baseline: 76% (having more than one living arrangement after 6 months in services)	B49

6. Demonstrate effectiveness of child and family services by maintaining improvement in clinical outcome at six months	FY 01: Maintain at 30% FY 00: Maintain at 30% FY 99: Not applicable, new measure	FY 01: TBR: 8/01 FY 00: TBR: 8/00 FY 99: 29% of children improved in their clinical outcome at 6 months FY 98: 32% of children improved in their clinical outcome at 6 months FY 97 Baseline: 29% of children improved in their clinical outcome at 6 months	
Total Funding:	**1997: $69,896,000** **1998: $72,927,000** **1999: $77,909,000** **2000: $82,763,000** **2001 Req: $86,763,000**		

2.22.1 Program Description, Content, and Summary of Performance

The goal of this program is to successfully implement "systems of care" for children with serious emotional disturbance and their families in grantee sites; and to improve outcomes for children and their families served in these systems of care. Since 1993, the Center for Mental Health Services (CMHS) has provided 45 grants in 29 states to develop comprehensive community-based systems of care for children and adolescents with serious emotional disturbance and their families. CMHS's Comprehensive Community Mental Health Services for Children and Their Families Program promotes system planning and system change to increase access to treatments and quality mental health services for children and their families in the community rather than in residential placements that are often costly and restrictive. In 1999, an estimated 15,600 children were served. Systems of care are implemented through collaborative arrangements across child-service sectors such as education, juvenile justice, child welfare, and mental health. As examples of system changes, referrals from juvenile justice programs have increased from 9.0% in 1997 to 18.2% in 1998 to the current level of 22.5%. Case records that reflect cross-agency treatment planning have increased from 40.0% in 1997, to 48.9% in 1998, to 58.0% in 1999. Based on 1999 data, children who enrolled in systems of care and spent time in residential facilities during the previous 12-months, saw their inpatient-residential days reduced from an average of 181 days at the time of enrollment to an average of 149 inpatient-residential days after one year in system-of-care services, an 18% improvement.

The increase in the budget for this program has permitted funding of more sites. Evaluation, technical assistance, and communication activities are an integral part of this program. Success to date is documented for the first group of sites in the following preliminary results. Based on data collected through August 1999 preliminary findings show notable improvements for children who are in services

for at least twelve months. For example, using standard measures, evaluation indicates that after one year:

- inpatient use decreased by 44 percent from an average of 265 days in 1997,
- regular school attendance increased by 27 percent from a 1997 baseline,
- no law enforcement contacts were reported for 43 percent of children with one or more contacts at service entry
- multiple living arrangements were reported for only 27 percent of children with multiple living arrangements at service entry

Most performance targets have been exceeded. Some targets were revised based on 1998 performance.

2.22.2 Goal-by-Goal Presentation of Performance

Performance Goal: Program goals for this program address Goal 2: Meet emerging and unmet. Measures focus on two major dimensions of this goal: 1) the efficiencies that can be achieved as the result of interagency collaboration and 2) the improvements of service outcomes.

Measure 1: Increase Interagency Collaboration as reflected below

Rationale: Interagency collaboration represents a key measure to indicate the degree to which a system of care for children with serious emotional disturbance and their families has been implemented. Collaboration across human service agencies is a critical component of the system of care approach. It helps to insure that the "whole" child will be served, funding resources for the treatment needs of the child will be maximized, and the opportunity for the child to have the optimum set of services available will increase. The set of indicators below examines the degree to which process features of the system-of-care approach result in increased interagency collaboration.

Data Sources and Validity of Data: Case record review data are derived from sources such as document reviews, structured and semi-structured interviews, and observations. These data are collected prior to and during annual sites visits. Data for the referral indicators are collected from a descriptive study of all children who enter systems of care and consent to participate in the evaluation of the grant program. There is relatively high agreement among project directors and others who implement systems of care that each indicator is a measure of interagency collaboration within systems of care.

Another indication of the validity of the data is the agreement between case record review and care giver report on the referral source. In Phase II of the national evaluation, data on referral sources are available from both case record review and care giver report. The correlation between information from

the two sources is 0.862 (p=.000) indicating a high degree of correspondence and supporting the validity of parent report of referral sources.

Baseline: See table 2.22 for multiple numbers.

Target: See table 2.22 for multiple numbers.

Progress Update: Two of the three targets were exceeded by a substantial margin. A 7.3% increase rather than a 10% target was achieved with respect to referrals from non-MH agencies. When FY 2000 data becomes available, the trend will be more evident and additional attention to this issue may be considered. FY 2001 Targets have been raised for the juvenile justice referral indicator and for the case record indicator because the FY 1998 and FY 1999 Targets were exceeded by a relatively wide margin. One Project Director reports his views on the consequences of increased interagency collaboration as follows ...

"[the governing body] gets involved in all of these functions [planning, policy development, developing service array, budget decisions, formal arrangements], how to coordinate resources across systems, how to fund placements, which pot of dollars to use. We've jointly funded a crisis shelter and a staff position. There's an open door for communication, it's the culture here, 3 - 4 [core] agencies stay really connected....it just makes sense, we serve the same kids."

Measure 2: Maintain Decrease in Utilization of Inpatient or Residential Treatment at 20 percent from 1997 base, as measured by average days in facility.

Rationale: Decrease of inpatient/residential treatment is highly consistent with the program goal of developing services for children with serious emotional disturbance in the community. Children with serious emotional disturbance have historically been served in inpatient/residential treatment programs because of a lack of community-based systems of care. Reducing reliance on residential facilities while at the same time creating service options within the community will demonstrate the development of community-based systems of care.

Data Source and Validity of Data: Data are derived from an instrument entitled Residential Living Environments and Placement Stability Scale which was developed by the Pressley Ridge School, Pittsburgh, PA. This scale incorporates an adapted version of the Restrictiveness of Living Environments Scale (ROLES) developed by Hawkins and colleagues (1992) with a Placement Stability Scale. Stability of placements is assessed by the number of days spent in each residential setting and the number of total placement changes over a specified data collection period. Utilization of inpatient or residential treatment is defined as the average number of days that children served in systems of care, who also were committed to an inpatient or residential facility during the previous year, lived in that facility. The measure excludes children who were served by the program but were not committed to a facility.

A recent analysis was conducted to compare parent report of inpatient placement on the ROLES-R to inpatient placement data in a management information system for the Wraparound Milwaukee program. Comparison of the two sources for the first six months that children participated in services revealed that parents overestimated the use of residential services, but there was a high degree of correspondence between the two data sources. The percentage of agreement for participation in inpatient services between the two data sources was 76%.

Baseline: FY 97 265 days, inpatient/residential treatment (avg days in facility)"

Target: For FY 2000 maintain 20% decrease. For FY 2001 achieve a 40% decrease.

Progress Update: FY 99 target has been exceeded. The FY 2001 Target was raised because the FY 98 and FY 99 Targets were exceeded by a relatively wide margin.

FY 99 6 months outcomes:131 days (N=171)
(51 percent reduction from FY 97 baseline)

FY 99 12 months outcomes: 149 days (N=118)
(44 percent reduction from FY 97 baseline)

A case history illustrates performance. One mother tells her story ...

"My son is 14 years old. He was in a state institution for 6 years and we didn't see him much. The System of Care staff came to meet our family and worked with us before our son came home, to get us ready. The case manager listened to us and asked us what we needed. We go to family therapy. Our younger son has had a hard time adjusting to having his brother home, so they sent a mentor for him, too, and include him in the recreation program. If only this program would have existed 6 years ago, our son would never have had to go away."

Measure 3: Improve Child Outcomes as reflected below

Rationale: Improvement in functional child outcomes can be used to demonstrate the extent to which a system of care makes a difference in a child's life. Studies have shown that school attendance correlates positively with overall school performance. There are also strong expectations that law enforcement contacts are reduced among children served through systems of care.

Data Sources and Validity of Data: These data are collected from a multisite outcome study. The two measures include information highly relevant to policymakers who are interested in observing functional improvements among children.

Information on the validity of school attendance data will be obtained by comparing data reported by care givers with information drawn from school records. For this analysis, one Phase I site which is in the Phase I Comparison Study will be used since the site has the school attendance data from both school records and care giver reports. Data are continuing to be collected for this comparison study. Analysis of the validity of parental reports of school attendance will be completed by August 2000.

For the contacts with law enforcement variable, data in the Phase I Comparison Study will be used to assess the validity of the information. In the Phase I Comparison Study, the information is collected from both the CAFAS care giver report and the Delinquency Survey youth self-report. Data from the two sources will be compared to obtain validity information.

Baseline: FY 1997, 70 percent school attendance and 47% with no law enforcement contacts after six months.

Progress Update: The school attendance target was exceeded.

FY 99 12-month outcomes: 88.9 percent attending school (27 percent increase from FY 97 baseline)

FY 99 12-month outcomes: 43 percent with no law enforcement contacts (4 percent decrease from FY 97 baseline)

The law enforcement contact Target was not exceeded. Originally it was expected that the percent of children with no law enforcement contacts would increase after six months in services. However, there was a slight decrease from the 1997 Baseline. This decrease can be attributed in part to a corresponding and relatively sharp increase in the number of children referred from juvenile justice programs, as seen in the results reported in Measure 1. Children referred from juvenile justice agencies have been found to enter systems of care at a higher level of need than children referred from child welfare, education, and other agencies (Walrath, Nickerson, Crowell, & Leaf, 1998). The FY 2001 Target for the school attendance outcome was raised slightly because FY 1998 and FY 1999 Targets were exceeded beyond the original expectations.

A case history illustrates performance. One mother reports her son's renewed interest in attending school after receiving system-of-care services.

"My son was always disinterested in school in regular activities kids enjoy; he didn't have any friends. But he liked music. They [the case management team] got him a guitar and into music lessons. He's changed now--he can focus. He'll go to school now willingly since he gets to work with the music teacher. He's even formed a band with some of the other kids."

Measure 4: Increase then Maintain Level of Family Satisfaction with Services

Rationale: Family satisfaction with services indicates the extent to which a child's care giver rates system-of-care services positively. Family involvement is a cornerstone of systems of care. Increasing the satisfaction rate of families who are receiving services is an indicator that the level and type of care is what the "customer" is desiring.

Data Source and Validity of Data: Data are derived from the Family Satisfaction Questionnaire (FSQ), an instrument adapted from the work of Professor John Burchard at the University of Vermont. Satisfaction measures are widely recognized as measures of service quality.

The validity of the level of satisfaction with services will best be assessed by correlating service information with satisfaction information. This can be done in the Phase II study, in which there are data available on both family and youth satisfaction, and experience with services. Measures that will be used to obtain validity information include Family Satisfaction Questionnaire (FSQ), Youth Satisfaction Questionnaire (YSQ), Multi-Sector Service Contacts (MSSC), and the Service Experience Questionnaire (SEQ). With information from different sources, and generated by different methods, it is possible to use the multi-trait multi-method matrix to

provide evidence of the validity of the satisfaction data. Preliminary analysis of these data will be completed by August 2000.

Baseline: FY 97 70 percent satisfaction with services.

Target: FY 2000 and 200, maintain at 10% the satisfaction with services.

Progress Update: FY 99 targets have been exceeded.

FY 99 6-month outcomes: 82.5 percent satisfied or very satisfied with services (17 percent increase from FY 97 baseline).

FY 99 12-month outcomes: 88.9 percent satisfied or very satisfied with services (27 percent increase from FY 97 baseline)

A case history illustrates performance. One mother provides her personal assessment of system-of-care activities ...

"*[my son] established his goals, they filled out a calendar of activities, what hobbies to support, classes he wanted to take...He's very artistic, the therapist made art supplies available, got him involved in rock climbing...also poetry classes, and had his poetry published.....It's a very good process, a very good program.*"

Measure 5: Increase stability of living arrangements by decreasing the number of children having more than one living arrangement after 6 months in services by 25 percent over FY 1997.

Rationale: Stability of the living arrangements represents a desired outcome for children, youth and their parents. A stable home environment is likely to be associated with many other protective factors for children with serious emotional disturbance. It is a crucial condition for child development and for an acceptable family environment.

Data Source and Validity of Data: Data are derived from an instrument entitled Residential Living Environments and Placement Stability Scale. This scale was developed by the Pressley Ridge School, Pittsburgh, PA, in order to operationalize the construct of restrictiveness. The scale also incorporates an adapted version of the Restrictiveness of Living Environments Scale (ROLES) developed by Hawkins and colleagues (1992) and a Placement Stability Scale. The stability of placements is assessed by the number of days spent in each residential setting and the number of total placement changes over a specified data collection period. The stability indicator used here refers to the percent of children for whom more than one living arrangement was reported over the last year in system-of-care services. Stability of a child's living arrangement is a functional goal of the program and is associated with other positive child outcomes.

A recent analysis to examine the validity of the stability measure was conducted using the Phase I longitudinal outcome study data. We examined the influence of stability of living arrangement on clinical and functional outcomes (i.e., CAFAS and CBCL scores) using repeated measures analysis of variance. It was hypothesized that children with stable living arrangements would have better clinical and functional outcomes than children with multiple living arrangements. Four groups were created based on whether a child had a single living arrangement or multiple living arrangements at baseline and at 12 months. Results indicated that care givers of children who either consistently experienced a single living arrangement over time or who experienced a reduced number of living arrangements from baseline to six months reported fewer externalizing problems and less functional impairment at 12 months than did care givers of children who consistently experienced multiple living arrangements over time or who experienced an increased number of living arrangements. Thus, the hypothesis was confirmed.

Baseline: FY 97: 76 percent, more than one living arrangement after 6 months in services.

Target: For FY 2000, 25% decrease. For FY 2001, 65% decrease.

Progress Update: FY 1999 targets have been exceeded. For FY 99, at 12 months a 64.5% decrease from baseline was observed. The FY 2001 Target was raised because the FY 1998 and FY 1999 Targets were exceeded by a relatively large margin.

FY 99 12-month outcome: 27 percent of children with more than one living arrangement (64.5 percent decrease)

Measure 6: Effectiveness of children and family services by maintaining improvement in clinical outcome at six months.

Rationale: The degree to which children change in a positive direction following participation in systems of care is an important indicator of program effectiveness. This can best be assessed by evaluating rates of clinically significant change in behavioral and emotional symptoms from entry into services to a consistent follow up assessment point. It has been reported that the greatest degree of change for children and adolescents participating in mental health services is likely to occur in the first six months following entry into services.

Data Source and Validity of Data: There is currently no data available to compare the positive change of children in a treatment condition (i.e., systems of care) with that of children in a control condition (i.e., usual service delivery systems). However, effectiveness data may be obtained by comparing independent cohorts of children served from one year to the next of the grant program. Reliable Change Index scores (Jacobson & Truax, 1991) were calculated from entry into services to six months for the Child Behavior Checklist (Achenbach, 1991). Based on these scores, children were classified into those displaying reliable positive change, those remaining stable and those displaying deterioration across time. The percentage of children displaying reliable positive change was calculated separately for the baseline period and each subsequent year.

The Reliable Change Index was developed to measure clinically significant improvement as a function of participation in an intervention program (Speer, 1998). The calculation formula controls for the reliability of a clinical measure before determining the amount of change necessary for a child to qualify as clinically improved from an initial assessment point to a second assessment point. The internal consistency value of .96 for the Child Behavior Checklist (Achenbach, 1991) was used to calculate Reliable Change Index scores. According to Speer and Greenbaum (1995), the Reliable Change Index is the most reliable and valid individual measure of clinically significant change that is currently available. A number of authors have provided data that supports the validity of the Reliable Change Index in measuring response to intervention (Lunnen & Ogles, 1998; Speer, 1998; Speer & Greenbaum, 1995).

Baseline: FY 1997, 29 percent improved clinical outcomes at 6 months.

Target: For FY 2000 and FY 2001, maintain at 30% rate of improved outcomes at 6 months.

Progress Report: This is a new measure. A reasonable target for clinical improvement during each year of the program was determined to be 30%. Additional studies should be conducted to assess further the reasonableness of the target.

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FY 99: 6-month outcome: 29 percent (same as FY 97 baseline)

2.23 Program Title: Access to Community Care and Effective Services and Supports (ACCESS) Cooperative Agreement Demonstration Program (KD Interim Report)

Performance Goals Goal 3: Bridge the gap between knowledge and practice	*Targets*	*Actual Performance*	*Refer-ence**
1. Improve client outcomes at 12 months for each cohort for the following characteristics:			B35
-Increased % stably housed	FY 01 NA (Program ended in FY 00) FY 00: 500% FY 99: 500%	FY 01: NA (Program ended in FY 00) FY 00 (Cohort 4 at 18 mos): TBA 10/00 FY 99 (Cohort 4): TBA 3/00 FY 98 (Cohort 3): 542.9% (Baseline=7%) FY 97 (Cohort 2): 528.6% (Baseline=7%) FY 96 (Cohort 1): 600.0% (Baseline=6%)	
-Decreased days drug use	FY 01: NA (Program ended in FY 00) FY 00: 15% FY 99: 15%	FY 01: NA (Program ended in FY 00) FY 00 (Cohort 4 at 18 mos): TBA 10/00 FY 99 (Cohort 4): TBA 3/00 FY 98 (Cohort 3): 19.1% (Baseline=1.94) FY 97 (Cohort 2): 37.6% (Baseline=3.03) FY 96 (Cohort 1): 45.5% (Baseline=3.89)	
-Increase days in outpatient psychiatric services	FY 01: NA (Program ended in FY 00) FY 00: 15% FY 99: 15%	FY 01: NA (Program ended in FY 00) FY 00 (Cohort 4 at 18 mos): TBA 10/00 FY 99 (Cohort 4): TBA 3/00 FY 98 (Cohort 3): 18.5% (Baseline=5.87) FY 97 (Cohort 2): 49.5% (Baseline=5.15) FY 96 (Cohort 1): 19.7% (Baseline=6.63)	
-Decrease % committing a minor crime	FY 01 NA (Program ended in FY 00) FY 00: 40% FY 99: 49%	FY 01: NA (Program ended in FY 00) FY 00 (Cohort 4 at 18 mos): TBA 10/00) FY 99 (Cohort 4): TBA 3/00 FY 98 (Cohort 3): 42.9% (Baseline=7%) FY 97 (Cohort 2): 50.0% (Baseline=8%) FY 96 (Cohort 1): 55.5% (Baseline=9%)	

2. Improve and then maintain level of systems integration	FY 01: NA (Program ended in FY 00) FY 00: .74 experimental .57 comparison FY 99: NA; (Data only collected in FY 94, FY 96, and FY 98)	FY 01: NA (Program ended in FY 00) FY 00 (Wave 4): TBR 10/00 FY 99: NA FY 98 (Wave 3):.66 experimental; .57 comparison FY 97: NA FY 96 (Wave 2):.57 experimental; .58 comparison FY 95: NA FY 94 (Baseline or Wave 1): .43 experimental, .45 comparison	B35
Total Funding:	**1997: $19,568,000** **1998: $ 1,891,000** **1999: $ 1,843,000** **2000: $0** **2001 Req:$0**		

2.23.1 Program Description, Context, and Summary of Performance

The goal of the program is to examine the impact of integrated service systems on providing services to persons who are homeless and seriously mentally ill toward improving outcomes for this population. This program is a 5-year knowledge development program, initiated in 1993, that will: (1) identify promising approaches to systems integration; and (2) evaluate their effectiveness in providing services to persons who are homeless and seriously mentally ill.

This program is nearing completion. An evaluation is being conducted that has both a systems-level and client-level focus. The system level evaluation will document the implementation process of the systems integration approaches, identify implementation barriers and facilitators, and measure system outcomes. The client level evaluation will determine whether systems integration efforts result in improved service delivery, improvements in mental health, substance abuse and health status, rehabilitation, quality of life and permanent exit from homelessness. A sixth year of data collection has been added to examine whether systems integration efforts are sustained and client outcomes continue to improve beyond Federal funding. This data collection includes an 18 month follow-up on the 4th cohort (i.e., subjects enrolled into the study in the 4th year); a 4th wave (i.e., 4th follow-up of agency providers) of systems integration assessment. Results will be ready for full reporting in FY 2001.

2.23.2 Goal-by-Goal Presentation of Performance

Performance Goals: Performance goals for this activity focus on Goal 3: Bridging the gap between knowledge and practice, specifically, the purpose of this activity is to identify best practices for the target population of homeless individuals with serious mental illness. These measures examine the effectiveness of a particular approach in achieving systems integration, and the effect of that approach on client outcomes.

Measure 1: Improvements in client outcomes at twelve months for each cohort will be equal to or greater than the improvement at twelve months for the previous cohorts.

Rationale: Enhancing clinical services in both the integration and comparison groups should result in improvements in client outcomes. Future analyses will compare changes in access to services and supports between the integration and comparison sites to determine the extent to which an integrated services system has an impact on persons who are homeless with serious mental illness.

Data Source and Validity of Data: The subcontractor has extensive experience in conducting field research. Protocols are in place for data management, data processing, clean-up and quality control. The measurements used were from standard instruments. Representatives from the grantee sites and outside consultants will be employed in the analysis to provide reliable and valid findings. High validity and reliability are expected.

Baseline: See table 2.23 for multiple numbers.

Target: See table 2.23 for multiple targets.

Progress Update:

- Percentage stably housed: Twelve month performance for each of the cohorts exceeds the FY1999 target of 500%. This means that, on average, more than 40% of the population had stability in their housing arrangements.

- Days drug use: Twelve month performance for each of the cohorts exceeds the FY1999 target of 15%. On average, there was a 34% decrease in number of days of drug use for this population.

- Days in outpatient psychiatric services: Twelve month performance for each of the cohorts exceeds the FY1999 target of 15%. This means that this population reported, on average, a 29% increase in number of days using psychiatric outpatient services.

% committing a minor crime: Twelve month performance for each of the cohorts exceeds the FY1999 target of 40%. This means that, on average, only 4% of this population had reported committing a minor crime.

Measure 2: Increase level of systems integration to .74 in FY 1999. Maintain level of systems integration at .74 in FY 2000. The data for this measure was collected at baseline (Wave 1) and every 18 months thereafter (Waves 2-4). The final collection (Wave 4) will be done in FY 2000 and reported in FY 2001.

Rationale: ACCESS predicts that the level of systems integration at each of the project sites will increase over time during the life of the program. The level of systems integration is being tested as a predictor of services outcomes for homeless persons with serious mental illnesses.

Data Source and Validity of Data: The data for these measures were collected from interviews with representatives of agencies/subunits providing mental health, substance abuse, housing, primary care, and income maintenance services to homeless persons with a serious mental illness at each of the sites participating in the ACCESS study. The questions have been used in previous inter-organizational network studies. The subcontractor responsible for this data collection and analysis is one of few who have had experience conducting this type of research. Protocols are in place to assure consistency in data collection, coding, data management, data processing, clean-up and quality control. Representatives from the grantee sites and outside consultants will be employed in the analysis to provide reliable and valid findings. High validity and reliability are expected.

Baseline: FY 1994: .43 experimental, .45 comparison

Target: For FY 2000, .74 experimental, .57 comparison

Progress Update: FY 00 performance data will become available in FY01. Systems integration is measured by the proportion of relationships in a network of agencies that have multiple components for providing assistance (i.e., client referrals, information exchanges, and funding transfers). This measure of network strength reflects the tendency for organizations within each ACCESS site to develop and maintain multiple interagency ties involving client referrals, information flows, and funding exchanges for homeless persons with a serious mental illness. System integration is calculated for each site at each of 4 Waves (i.e., baseline and 3 follow-ups).

The computation of system integration scores involved three steps. First, because in this study the primary interest is in the presence of a relationship rather than the strength of the relationship, each reported service linkage between agencies in a city is dichotomized for each client, information, and fund network by recording all responses greater than 0 to 1. Second, a multiplex linkage score is computed by summing the dichotomized scores across six networks (for two relations–sending and receiving, and three contents–clients, information, and funds). If for the six possible values of a relationship, at least two or more are present, the relationship is defined as multiplex. Third, the

system-level integration score for each site is then computed as the ratio of the number of multiplex relations over N*N-1, the total number of possible directed relationships with the network. Thus, the system-level integration score is a proportion ranging between 0 and 1, where 0 means that there are no resource exchanges among the organizations and 1 which means all possible relationships were determined to be multiplex given the criteria above.

The measures of systems integration that were collected at Wave 1 (FY 1994) and at the two mid-points (FY 1996 and FY 1998) indicate that, over time, the experimental sites were able to develop more integrated service systems than the comparison sites. It is expected that the level of systems integration will continue to increase in the experimental sites and remain constant or decrease in the comparison sites if the experimental sites continue to implement systems integration strategies. The final measure of systems integration, which will be collected during FY 2000, should be approximately .74 for the experimental sites and .57 for the comparison sites.

2.24 Program Title: Employment Intervention Demonstration Program (EIDP) (Knowledge Development) Interim Report

Performance Goals *Goal 3: Bridge the gap between knowledge and practice*	*Targets*	*Actual Performance*	*Refer-ence*
1. Employment rate of participants	FY 01: N.A.; program over FY 00: 50% employed FY 99: No target set	FY 01: N.A.; program over FY 00: TBR 10/00 FY 99: 51% employed FY 98: 50% employed FY 95 baseline: participants not working in order to enter program in all but one site	B35
2. Total number hours worked by participants during the program	FY 01: N.A.; program over FY 00: 1,000,000 hours FY 99: No target set	FY 01: N.A.; program over FY 00: TBR 10/00 FY 99: 793,577 hours FY 98: 346,405 hours FY 95 baseline: N.A.; no participants yet enrolled	
3. Total dollars earned by participants during the program	FY 01: N.A.; program over FY 00: $5.5 million FY 99: No target set	FY 01: N.A.; program over FY 00: TBR 10/00 FY 99: $4.2 million FY 98: $1.8 million FY 95 baseline: N.A.; no participants yet enrolled	

Total Funding:	**1997: $4,840,000** **1998: $4,749,000** **1999: $4,231,000** **2000: $846,000** **2001Req: $846,000**		

2.24.1 Program Description, Context and Summary of Performance

The Employment Intervention Demonstration Program (EIDP) is a 5-year multi-site demonstration program that began in 1995. The goal of the program is to develop knowledge of the most effective approaches for assisting adults with serious mental illness to find and maintain competitive employment. Each of the eight participating project sites is evaluating at least two employment support service models. All are collecting data using a common research protocol. A coordinating center is merging data from the eight sites into a common database so that results across sites can be combined and compared. In addition to individual outcome data, data on the costs of the programs are also being collected.

Enrollment in EIDP is now complete with 1658 participants enrolled across all eight sites. Participants at seven of the sites were not working when they entered the program. One site (Pennsylvania) is examining the effectiveness of Long-Term employment supports in assisting people who are already working to maintain employment. The participants in Pennsylvania, therefore, were already employed when they entered the program. Overall, only 13% of the participants were employed when they first entered EIDP.

Each participant is followed for two years after their initial enrollment in the program. Data collection will end in FY00. Preliminary data analyses indicate that people with serious mental illnesses are employable and can be productive workers. It also appears that the longer someone is enrolled in employment support services, the more likely they will be to find a job. Data from the study will provide much information on the types of reasonable accommodations required in order for people with serious mental illness to maintain employment, the characteristics of the jobs that they attain, and how public entitlements and the fear of losing them affect decisions about work. The final report (expected in 2001) will include comprehensive statistical analyses of the cross-site data set, as well as an analysis of program costs.

2.24.2 Goal-by-Goal Presentation of Performance

Performance goals for this activity involve Goal: 3 “Bridge the Gap Between Knowledge and Practice.” Performance measurement emphasizes the key outcome measures that are being assessed by this multisite research project: employment rate, hours worked, and dollars earned. Originally, Measure 1 stated that “Employment outcomes will significantly improve at intervention projects.” In FY99,

Measure 1 was divided into Measures 1-3 to improve clarity and precision of reporting. Because the specific types of employment outcomes to be reported were not defined until FY99, targets were first set for FY00. Data were available, however, and are reported here for previous years, even though no targets had been set.

Measure 1: Intervention projects will have a significant impact on the employment rate of participants.

Rationale: The program will report on an annual basis the proportion of participants who have been employed during their first year of participation in the program. The program will demonstrate how appropriate supports can affect the ability of people with serious mental illness to attain jobs.

Data Source and Validity of Data: Data on employment status are collected from each participant each week of their participation in the project. The coordinating center combines the data from all participants at all sites and reports an aggregate percentage employed. The number reported by the coordinating center is the percentage of participants employed at any time during the first year of their enrollment in the program. The data reported are for all participants who have received services for one year as of October of the year reported. Because this is a knowledge development project, complex analyses will be performed after completion of all two-year follow-up interviews in order to gain a comprehensive understanding of the many variables contributing to the employment of people with serious mental illness in this program. In order to preserve the scientific blind of the study, the data represent information gained from the combined sample of experimental (best practices) and control (standard services) conditions. The scientific blind will help to assure the validity of the final results. We expect that the final report will show that the numbers reported here underestimate the rate of employment for people enrolled in the experimental services and overestimate it for those enrolled in the control services.

Baseline: FY 1995, no participants are working.

Target: FY 2000, 50% of participants employed.

Progress Update: Progress in FY'99 demonstrates that the percentage of people who become employed during the first year in which they receive employment support services is consistent with earlier, more preliminary findings.

Measure 2: EIDP will demonstrate the economic productivity potential of people with serious mental illness by reporting the total number of hours worked by participants during the course of the program.

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Rationale: The program will report on an annual basis the total number of hours worked by participants during the course of the program. The program will demonstrate the job productivity that people with serious mental illnesses can achieve with appropriate supports.

Data Source and Validity of Data: Data on number of hours worked are collected from each participant each week of their participation in the project. The coordinating center combines the data from all participants at all sites and reports an aggregate number of hours worked. The number reported is the total number of hours worked by all participants during their enrollment in the project as of October of the year reported. The number reported, therefore, is cumulative for the life of the project. Final analyses of the data at the end of the project will allow us to more precisely determine the average number of hours worked by each participant and how worker productivity relates to receipt of employment support services.

Baseline: FY 1995, no participants yet enrolled. FY 1998, 346,405 hours.

Target: FY 2000, 1 million hours.

Progress Update: Progress in FY'99 demonstrates that the total hours worked by EIDP participants doubled from the FY'98 level.

Measure 3: EIDP will demonstrate the earning potential of people with serious mental illness by reporting the total dollars earned by participants during the course of the program.

Rationale: The program will report on an annual basis the total dollars earned by participants over the course of the demonstration. The program will demonstrate the earning potential that people with serious mental illnesses can achieve with appropriate supports.

Data Source and Validity of Data: Data on dollars earned are collected from each participant each week of their participation in the project. The coordinating center combines the data from all participants at all sites and reports an aggregate dollars earned. The number reported is the total dollars earned by all participants during their enrollment in the project as of October of the year reported. The number reported, therefore, is cumulative for the life of the project. Final analyses of the data at the end of the project will allow us to more precisely determine the average dollars earned by each participant and how earning potential relates to receipt of employment support services and public entitlement benefits.

Baseline: FY 1995, no participants yet enrolled. FY 1998, $1.8 million dollars earned.

Target: FY 2000, $5.5 million.

Progress Update: Progress in FY'99 demonstrates that the total dollars earned by EIDP participants more than doubled from the FY'98 level.

2.25 Program Title: Knowledge Exchange Network (KEN)

Performance Goals *Goal 3: Bridge the gap between knowledge and practice*	*Targets*	*Actual Performance*	*Reference*
1. Increase usefulness of KEN information	FY 01: FY 00: TBD 11/00 FY 99: No target set	FY 01: TBR 11/02 FY 00: TBR 11/01 FY 99: TBR 11/00	B35
2. Increase number of:			B35
- Information request	FY 01: Increase to 63,286 FY 00: Increase to 57,533 FY 99: Increase to 30,302	FY 01: TBR 10/02 FY 00: TBR 10/01 FY 99: 52,303 FY 98: 27,642 FY 97: 26,603 FY 96: 10,324	
- Publications distributed	FY 01: Increase to 355,222 FY 00: Increase to 322,929 FY 99: Increase to 153,903	FY 01: TBR 10/02 FY 00: TBR 10/01 FY 99: 293,572 FY 98: 139,912 FY 97: 107,087 FY 96: 53,932	
- BBS connections	FY 01: N.A. FY 00: N.A. FY 99: Increase to 53,289	FY 01: N.A. FY 00: N.A. FY 99: 39,868 FY 98: 48,445 FY 97: 91,033 FY 96: 39,026	
- Web site sessions	FY 01: Increase to 440,407 FY 00: Increase to 400370 FY 99: Increase to 197,659	FY 01: TBR 10/02 FY 00: TBR 10/01 FY 99: 363,973 FY 98: 179,690 FY 97: 79,093 FY 96: 11,108	

Total Funding:	**1997: $ 665,285** **1998: $ 453,421** **1999: $1,158,611** **2000: $3,500,000** **2001 Req:$3,500,000**		

2.25.1 Program Description, Context, and Summary of Performance

The goal of the program is to provide information about mental health via various media to users of mental health services, their families, the general public, policy makers, providers, and researchers.

Summary of Performance: The number of requests for materials, connections to the web site and publications distributed have shown significant increase since 1996 and most targets have been met. Current FY 99 performance data for measure 2 was reported in October, 1999. Establishing targets for increasing the usefulness of KEN information, measure 1, is dependent on the collection and analysis of survey data, reporting began in November 1999 with baseline to be established in November 2000.

2.25.2 Goal by Goal Presentation of Performance

Performance goals: Performance goals for this activity involve Goal 3: "Bridging the Gap between Knowledge and Practice." Performance measurement emphasizes the utilization of the Clearinghouse and the usefulness of the information it distributes.

Comments on Measures: Measure one will be used during the development of a replacement measure. Targets for the new measure will be reassessed as data are reviewed.

Program Update/Performance Report**:** Activity is greatly increased. Advancements in technology has made the bulletin board service (BBS) not a useful approach to dissemination. This services was terminated on 12-1-1999. Web site started operations April 1, 1996. As more users of KEN make use of the Internet to request information we expect to see a decrease in the number of individuals making use of the KEN 1-800 telephone service for basic information request.

Measure 1: Increase the usefulness of KEN information.

Rationale: Usefulness will be assessed by response to a KEN user satisfaction survey.

Data Source and Validity of Data: Online Internet user survey. Validity of responses is expected to be high.

Baseline: The customer satisfaction survey was submitted for OMB approval in August 1999. User assessment of the usefulness of KEN information will began in mid FY 2000.

Target: TBD 11/00

Progress Update: OMB approval was received and the customer satisfaction survey went online in late October 1999. Analysis of data has began. We will begin to develop baseline mid FY 2000.

Measure 2: Increase by 10% each year the number of: information requests, publications distributed, BBS connections and website hits.

Rationale: These data provide a concrete measure of successful performance. The increase in use of KEN indicates the need for and usefulness of this information and format.

Baseline: FY 1998 27,642 Information request
139,912 Publications distributed
48,445 BBS connections
179,690 Web hits

Target: FY 1999, exceed the FY 1998 hits and inquiries. See table 2.25 for specific values.

Data Source and Validity of Data: Monthly reports from KEN contractor. Validity of data is high, as these monthly summaries provide accurate reports on various aspects of the KEN project.

Progress Update: The bulletin board is no longer running and was discontinued in 1999. All other targets were exceeded.

2.26 Program Title: Community Action Grants for Service Systems Change (CAG) (Interim Report)

Performance Goals *Goal 3: Bridge the gap between knowledge and practice*	*Targets*	*Actual Performance*	*Refe r- ence*
1). Achieve Consensus To Implement the Exemplary Practice (EP)	FY 01: Maintain 85% Consensus FY 00: Maintain 85% Consensus FY 99: Maintain 85% Consensus	FY 01: TBR 01/03 FY 00: TBR 01/02 FY 99: TBR 06/01 FY 98: TBR 05/00 FY 97 Baseline: No Consensus	B40

2). Successfully Implement the Exemplary Practice	FY 01: 50% Implement FY 00: 50% Implement FY 99: 50% Implement	FY 01: TBR 10/03 FY 00: TBR 10/02 FY 99: TBR10/01 FY 98: TBR 05/01 FY 97 Baseline: TBR 10/00	B40
Total Funding:	**2001 Req: $5,500,000** **2000: $4,500,000** **1999: $3,275,000** **1998: $3,129,000** **1997: $2,474,000**		

2.26.1 Program Description, Context and Summary of Performance

The goal of this two-phase program is to assist communities: Phase I - Achieve Consensus to implement exemplary practices and Phase II -Successful Implementation of these exemplary mental health practices for a target population that consists of adults with serious mental illness and adolescents/children with serious emotional disorders. Phase II has been initiated, however, data to establish the baseline level of implementation has not yet been collected.

Program Update/Performance Report: In FY 1997, twenty Phase I Community Action Grants were awarded. In FY 1999, eleven of these twenty Phase I grantee were awarded Phase II grants.

On September 30, 1998 the Center for Mental Health Services, in partnership with the Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention, initiated the second round of Community Action Grants (CAGs) to assist State and community groups adopt "exemplary" practices. The second round of CAGs includes a Basic Program - focused on exemplary mental health practices for the target population and a Hispanic Initiative - focused on exemplary mental health, substance abuse and integrated mental health/substance abuse practices for Hispanics.

A total of thirty-one grants - each up to $150,000 for one year - were awarded: 20 in the Basic Program; 11 in the Hispanic Initiative.

On September 30, 1999 a total of sixteen Phase I CAG grants were awarded; 10 in the Basic Program; six in the Hispanic Initiative.

The next Community Action Grant Program announcement will be a Program Announcement (PA) or "standing announcement," that includes both Phase I and Phase II and be available twice a year. The PA will provide an opportunity for unsuccessful applicants to re-apply more than once per year. Current plans are to announce the PA by the end of 1999.

Current Phase I activities funded through the basic CAG program include 36 exemplary practice models directed at adults and 8 with a focus on adolescents/children. This number includes the Hispanic initiative.

Examples of successful Phase II activities to date include:

Rural South Carolina and the City of Berkeley (California) are now implementing the Program for Assertive Community Treatment (PACT) - a proven and effective clinical team approach for the serious mentally illness.

Western Pennsylvania, Washington, D.C. , and Mississippi are implementing service models for children and adolescents coping with serious emotional disorders. Also, in Pennsylvania, a Phase II Family Education Model is being implemented in rural Berks, County.

Other Phase II models are being implemented in the States of Washington (Elderly Outreach), Texas (Police Training and Jail Diversion, State of Maine (family psycho education and Massachusetts (Dual Diagnosis Model).

The police training and jail diversion projects in Texas are being implemented in the Fort Worth (Tarrant County) area and the City of Houston which is also Harris County, the fourth largest metropolitan area in the U.S.

Comments on Measures: Baseline data for all Community Action Grants (Phase I and II) is provided within the performance scale.

2.26.2 Goal-by-Goal Presentation of Performance

Measure 1: 50% of Phase I grantees achieve consensus to implement the exemplary practice(s).

Rationale: Phase I grants are one year grants. The goal of these grants is to reach consensus or agreement among all key stakeholders that the exemplary practice can and should be implemented. Consensus must be in sufficient detail that it resolves all critical issues and represents a commitment to adopt the practice within a certain timetable.

Data Source and Validity of Data: Program records of grant reports and a process evaluation that will be submitted by each grantee will be evaluated to determine common issues/variables across grant programs.

Baseline: FY 1997, no consensus.

Target: FY 2000 and FY 2002, 85% consensus.

Progress Update: Performance data for Phase I is reported in the performance chart and additional data will be available in 2000.

Measure 2: Fifty Percent (50%) of exemplary practices that were funded as Phase II grants are successfully implemented into services delivery.

Seventeen (17) of the FY 1997 Phase I Grantees applied for Phase II funding in 1999. Seventy percent (70%) or 12 of these successful Phase I grantees obtained Phase II funding. Baseline data for these Phase II grants will be available in 2000.

Thirty-one (31) new Phase I Grants were awarded in FY 98 and Sixteen(16) new Phase I grants in FY 99. It is projected that 50% of the 47 Phase I grantees successfully compete for a Phase II award.

Rationale: The first Phase II grants were awarded in FY 1999. Phase II grantees are funded for 1 year. Since these grants were not awarded until FY 1999, all targets will be revised when these Phase II grantees achieve implementation of the EP and baseline percentages are established.

Data Source and Validity: Program records of grant reports and a process evaluation that will be submitted by each grantee will be evaluated to determine common issues/variables across grant programs.

Baseline: No implementation.

Target: For FY 2000 and FY 2001, 50% will implement the exemplary practice.

Progress Update: Performance data for Phase II will become available beginning in 2000.

Managed Care

The mission of the Office of Managed Care (OMC) strives to improve the access and quality of services received by consumers and family members under managed care systems in public mental health and addiction programs.

One program is included in this GPRA report.

2.27 Managed Care (Goal 3)

This program reports data annually.

2.27 Program Title: Managed Care Program (Knowledge Application)

Performance Goals *Goal 2: Meet emerging and unmet needs*	*Targets*	*Actual Performance*	*Refer-ence*
1. Number of reports cumulatively totaled published on managed mental health/substance abuse services	FY 01: 9 reports FY 00: 6 reports FY 99: 3 Reports	FY 01: TBR FY 00: TBR FY 99: 3 Reports	
2. Satisfaction with training on managed mental health and substance abuse issues	FY 01: Maintain at 80% FY 00: 80% FY 99: New measure in FY 00	FY 01: TBR 9/01 FY 00: TBR 9/00 FY 99: TBR 1/00-need OMB clearance on satisfaction instrument FY 1998: 81% satisfied/highly satisfied. Previous 1998 Baseline: 85% was estimated; 81% based on actual	
3. Reported satisfaction with Managed Care procurement, contracting and monitoring	FY 01: 10 states FY 00: 10 States FY 99: 10 States	FY 01: TBR 7/01 FY 00: TBR 7/00 FY 99: TBR 5/00 FY 98: Baseline 0 States	
4. Release and use of detailed managed mental health and substance abuse quality management and accreditation guidelines	FY 01: 2/3 of the States negotiating Medicaid managed care contracts FY 00: ½ of the States negotiating Medicaid managed care contracts FY 99: New measure in FY 2000.	FY 01: TBA 9/01 FY 00. TBA 9/00. Survey of Medicaid contracts will be repeated. FY 99: Report due end of August, 1999 on progress and resolving problem areas identified by earlier studies.	
Total Funding:	**Funding from SAPT and CMHS Block Grant Set-asides**	*Funding is drawn from all three centers.	

2.27.1 Program Description, Context, and Summary of Performance

The goal of this program is to promote the availability of effective services to persons enrolled in managed care. The Managed Care Initiative strives to improve the access and quality of services received by consumers and family members under managed care systems in public mental health and addiction programs. The program focuses on tracking state contracting and program implementation; developing technical assistance and training for consumers, family members, state and federal leaders, providers and advocates; supporting the development of quality improvement measures sensitive to mental health and substance abuse needs; and producing reports on emerging legal and other managed care system issues.

In FY 1999, the Managed Care Initiative accomplished many activities related to the four measures, despite unavailable measurement data due to outside factors for the last two measures. The Initiative far exceeded expectations of published reports that further understanding of the states' rapid installation of managed care programs and that support technical assistance to consumers, advocates and policy makers. By FY1999, 27 total reports were published since FY1997 whereas the goal was 9 total reports by FY2000. Training efforts expanded with a doubling of provider trains to 50 and the development of grassroots training taught by consumers and family members on public managed care contract design and monitoring. The standardized instrument to document satisfaction was approved by OMB late in the year, and therefore, a compilation of data from the evaluations will be available in early 2000. Measuring the impact of efforts to include consumers and family members in managed care systems for children depends upon the completion of the 10 states impact study due in spring of 2000. Similarly, the HCFA implementation of guidelines needed for QISMC have been slower than expected. Nonetheless, the GW contracts evaluation study to be delivered shortly will shed light on current practices prior to QISMC and collaborative relationships with HCFA on QISMC will continue.

2.27.2 Goal-By-Goal Presentation of Performance

Performance Goals: Performance goals for this activity relate to Goal 2: Promote the Adoption of Best Practices, through improving access and quality of mental health and substance abuse services for consumers and family members in managed care systems. The following measures address activities to accomplish the goals and progress is noted on each:

Measure 1: Publication of nine reports on managed mental health and substance abuse services

Rationale: Publication of reports is central to the main goal of the program. Published reports further the understanding of the states' rapid installation of managed care programs and that support technical assistance to consumers, advocates and policy makers. As the nation's mental health and substance abuse prevention and treatment systems are being transformed by managed care, it is essential that SAMHSA track and report developments, problems, and successful projects so that successful experiments can be replicated and problems can be avoided. No authoritative, consolidated source of information exists in the Federal government or elsewhere that provides an easily accessible source of knowledge about utilization, costs, consumer and provider characteristics and outcomes from the myriad changes being introduced throughout the MH/SA field by managed care.

Data Source and Validity of Data: Program documentation will capture the number of reports published The validity of the data is thought to be high.

Baseline: Under 3 reports.

Targets: FY1999: 9 Reports; FY2000: 9 Reports; FY2001: 9 Reports

1999 Progress Update: The number of reports far exceeds the 2000 goal. By the end of 1999, the Managed Care Initiative has published a total of 27 reports and anticipates 5 more documents in year 2000. The following summarizes the reports:

1997 Progress Update (2 total at baseline):

Evaluation Study of Legal Issues in Contracts between Managed Care Organizations and Community-based Mental Health and Substance Abuse Agencies

Evaluation Study of Legal Issues in Contracts Between State Medicaid Agencies and Managed Care Organizations in a Managed Care Environment

1998 Progress Update (15 reports this year; 17 commutative total):

Actuarial Study of the Costs of Implementing Mental Health and Substance Abuse Parity Coverage at Varying Levels of Intensity of Management of Care;

National Expenditures for Mental Health, Alcohol and Other Drug Abuse Treatment;

Evaluation of Legal Issues in Medicaid Managed Behavioral Health Care Contracts;

Designing Substance Abuse and Mental Health Capitation Projects;

Estimating and Managing Risks for the Utilization and Cost of Mental Health and Substance Abuse Services in a Managed Care Environment;

Ethical Issues for Behavioral Health Care Practitioners and Organizations in a Managed Care Environment;

Legal Issues Associated with Development and Implementation of Provider-sponsored Managed Care Organizations;

Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers;

A Guide for Providers of Mental Health and Addictive Disorder Services in Managed Care Contracting;

Partners in Planning: Consumers' Role in Contracting for Public-sector Managed Mental Health and Addiction Services;

Managed Care Tracking Project Newsletters--February and July;

Coverage Decision-making in Medicaid Managed Care: Key Issues in Developing Managed Care Contracts;

An Overview of Medicaid Managed Care Litigation;

Selected Key Issues in the Development and Drafting of Public Managed Behavioral Health Care Carve-out Contracts

<u>1999 Progress Update (10 reports this year; 27 total):</u>

Partners in Planning: A Quick Reference Guide;

Managed Care Tracking Project--Newsletters in January, July and August;

Managed Care Tracking Project--State Profiles;

Cultural Competence in Medicaid Managed Care Purchasing: General and Behavioral Health Services for Persons with Mental and Addiction-Related Illnesses and Disorders;

Health Affairs Articles--Behavioral Health Benefits in Employer-Sponsored Health Plans and Mental Health/Medical Care Cost Offsets: Opportunities for Managed Care;

A Summary of Planned Mental Health and Substance Abuse Services and Activities in Title XXI Programs

Managing Child Welfare: An Analysis of Contracts for Child Welfare Service Systems

<u>2000 Targets Update (5 reports projected; 32 total commutatively):</u>

Evaluation of Legal Issues in Medicaid Managed Behavioral Health Care Contracts;

Consumer Bill of Rights and Responsibilities--Four publications

Managed Care Tracking Project--Three newsletters

Measure 2: Coalitions of community MH/SA agencies for consumers, families, and advocates for persons who are mentally ill or substance abusers, and for State and county MH/SA and Medicaid agencies will receive training on managed MH/SA issues that they have identified as priorities, and at least 80% will report satisfaction with the training and a commitment to use their new knowledge and skills.

Rationale: The lessons learned from health care reforms needs to be shared, and skills taught to enable consumers, families, providers, MCOs, and purchasers to make best use of the new options that managed care makes available.

Data Source and Validity of Data: Satisfaction and commitment to use reports will be derived from a survey of participation in training offered to at least 15 state-wide coalitions of community MH/SA agencies; 15 national and state-wide coalitions of consumers, families, and advocates for persons who are mentally ill or substance abusers or who are at risk for these disorders; and all 50 State mental health, substance abuse, and Medicaid agencies.

Baseline: Little systematic training is being done for MH/SA provider organizations, consumers and families, and joint training of State and county MH/SA and Medicaid officials; information regarding success of training is not available.

Targets: First measure in FY2000; 80%; FY2001: Maintain at 80%

1999 Progress Update: Training managed care procurement and contract monitoring for consumers, families, and advocates were held in at 20 States through 1999 using SAMHSA developed materials. A dissemination strategy has been developed that has included input from direct consumers and families who participated in developing the contracting guide. A series of 20 managed care training programs for State-wide coalitions of mental health and substance abuse agencies has been set up by SAMHSA that will work with the Legal Action Center and the National Council for Community Behavioral Health care.

The series of 20 managed care training programs for State wide coalitions of mental health and substance abuse agencies has ballooned into almost 50 training programs. A standardized instrument will be used to measure satisfaction and was approved by OM and was approved by OMB late in the year. Because of this delay, the 15 training events that took place this year could not use a standardized instrument and no data will be available until next year.

Training is progressing for consumers, families, and advocates on managed care procurement and contract monitoring. Five consumer trainers who helped develop the Partners in Planning Guide: Consumers' Role

in Contracting for Public-Sector Managed Mental Health and Addictive Services are now presenting this information at national conferences, such as the SAMHSA Women's Conference and the IASPRS annual meeting. They are also active at the grassroots level of the community, training in small groups to locally interested consumers where there is publically managed behavioral health care. Because of the diverse nature of the training sessions, a standardized instrument is not possible for measurement but all consumer/family trainers will submit evaluation reports that will be closely examined.

Measure 3: In at least ten States with active public managed MH/SA systems, representatives of consumer and family organizations contacted by the SAMHSA Public Managed Care Monitoring and Tracking Project will report satisfaction with their involvement in MC procurement, contracting and monitoring.

Rationale: Consumers and family members have made very important contributions to Federal, State, and county MH/SA systems over the last decade. However, consumers and their advocates report being extremely frustrated by their lack of involvement in managed care systems and generally feel that their needs are not being well served. SAMHSA supports efforts to develop service systems that are responsive to the needs of consumers, and involve consumers in treatment decisions, and in program planning, decision making, and evaluation.

Data Source and Validity of Data: The SAMHSA Public Managed Care Monitoring and Tracking Project for children and adolescents will begin in FY 1998 to systematically assess consumer and family organization satisfaction with their participation in planning, implementing and monitoring MH/SA managed care.

Baseline: 0 States

Targets: FY 2000: 10 states; FY 2001: 10 states

Intensive training was provided for consumer and family representatives who are involved in reviewing Arkansas Medicaid managed care proposals.

Assessment of consumer/family involvement in children managed behavioral health care planning indicates general satisfaction in 4 of 10 States intensively studied.

Five training sessions have been provided at national meetings of consumers and families, and 4 training sessions have been provided to State and local coalitions of consumers and families. Additional training is planned throughout 2000.

Progress Update: The reporting of the 10 state survey has been delayed and is now expected in the spring of 2000. Of interest, the fifty state profile report released in 1999 reported 28% of families report significant involvement in initial stages of managed care planning and 38% of families report such involvement in current refinements. Perhaps this greater involvement at later stages indicates a trend toward

greater inclusion as programs mature. In addition, 45% of reforms reportedly provide funding for family organizations to play a role in managed care systems.

Measure 4: Release of detailed managed MH/SA quality management and accreditation guidelines by SAMHSA, and use of these guidelines by at least half of the States negotiating Medicaid MH/SA managed care contracts.

Rationale: There is no agreed-upon standard for quality management of MH/SA managed care systems that the Federal government and States use. This is a problem identified in the GWU studies of Medicaid managed care contracts that may contribute to limited access, consumer grievances, and poor outcomes. NCQA, JCAHO, CARF, COA, and Federal purchasers (DOD, DVA, Medicare) are developing and testing MH/SA managed care accreditation and quality management guidelines.

Data Source and Validity of Data: To survey the quality management and accreditation standards used by states, the annual GWU legal analysis of Medicaid MH/SA MC contracts will track inclusion of standards in RFPs, contracts, and contract amendments.

Baseline: No guidelines for important program areas.

Targets: FY1999: First measure in FY2000; FY2000: ½ of the states negotiating Medicaid managed care contracts; FY2001: 2/3 of the states negotiating Medicaid managed care contracts

Progress Update: The GWU review of Medicaid managed behavioral health care contracts current through the beginning of 1997 found little improvement from the baseline 1995 survey.

In fall, 1999, GWU submitted a draft evaluation report that describes the progress made in Medicaid managed behavioral health care contracts in the areas in which problems were identified in the 1995 and 1996 surveys. The report is in the preliminary review stages and will be available in early 2000. In addition, the 1999 GWU study will chart progress that Medicaid contracts have made in the consumer protections outlined in the Consumer Bill of Rights.

SAMHSA actively participated with HCFA in developing Quality Improvement Standards for Managed Care (QISMC), which will be the accreditation standards for Medicare and Medicaid managed care. SAMHSA is jointly developing with HCFA implementation guidelines for QISMC and training programs for State officials and Peer Review Organizations. Training events will be scheduled starting Spring, 1999. GWU will follow-up and review Medicaid contracts current through 1999 to further monitor progress on problem areas, and will conduct a second annual study of child welfare managed care contracts to assess improvements.

The GWU evaluation of progress in Medicaid managed behavioral health care contracts was submitted, in draft, September 1999 and will be available in early 2000. This will provide the baseline of current practices against which to measure future effects of quality initiatives.

SAMHSA has worked intensively with HCFA on the development of QISMC. The final protocols for Medicaid are currently under development. HCFA, with SAMHSA support, is planning a national training conference in the spring 2000 for state government officials which will focus on quality improvement and assurance.

Substance Abuse National Data Collection

The Office of Applied Studies serves as a focal point for the data collection, analysis, and dissemination activities of SAMHSA. OAS is involved primarily in collection and analyzing data on the incidence and prevalence of substance abuse, the distribution and characteristics of substance abuse treatment facilities and services, and the costs of substance abuse treatment programs.

Programs included in this section, all of which report results on an annual basis, are:

Goal 4: Invest in data for quality improvements and accountability.
2.28 Household Survey Expansion
2.29 Drug Abuse Warning Network
2.30 Drug Abuse Services Information System

2.28 Program Title: Expanded National Household Survey on Drug Abuse (NHSDA)

Performance Goals	*Targets*	*Actual Performance*	*Refer-ence*
1: Availability of data collection system in calendar year 1999	FY 01: None FY 00: None FY 99: System available in FY 1999.	FY 01: N.A. FY 00: N.A. FY 99: System is available. One-time target has been met. Measure should now be dropped FY 98 Baseline: No system	B127
2: Availability and timeliness of data in calendar year 2000	FY 01: Maintain at 8 months after close of data collection FY 00: National and State data to be available 8 months after close of data collection FY 99: National data to be available 8 months after close of data collection.	FY 01: TBR FY 00: TBR FY 99: Data available within 8 months of data collection: target reached. FY 98 Baseline: National data were available 8 months after close of data collection.	B127
Total Funding:	**1997: $16,792,000** **1998: $29,474,000** **1999: $36,921,000** **2000: $47,763,000** **2001 Req: $39,555,000**		

** Includes $6.5 million for Tobacco Expansion Module and $340,000 from Mental Health Block Grant Set-aside.

2.28.1 Program Description, Context, and Summary of Performance

The goal of this program is to provide estimates of the prevalence of substance abuse at the national level and in the 50 States and the District of Columbia. This program collects annual data on substance abuse based on a national probability sample of the civilian population age 12 and older. The survey is used to provide information on the prevalence of substance abuse and perceptions of risk in the population, and the sociodemographic characteristics, criminal, and other behavioral activities of individuals with a substance abuse problem. In 1999, the NHSDA sample increased from 25,000 to 70,000 so as to generate State level estimates of substance abuse prevalence.

Data collection for the expanded NHSDA began in January, 1999, and is ongoing. In FY 1998, national data from the 1997 survey were made available to the public 8 months after the close of the data collection period. The progress in FY 1999 puts the program on course to maintain this target for

data from the 1998 and 1999 surveys. State and national level data from the expanded survey should be available in August, 2000.

2.28.2 Goal-by-Goal Presentation of Performance

Performance Goals: Performance goals for this activity relate to Goal 4: Invest in data for quality improvements and accountability. The product of this initiative is relevant, accurate, and timely data to be used as performance measures by the Office of National Drug Control Policy and other Federal and State agencies engaged in efforts to reduce substance abuse.

Measure 1: Availability of data collection system in calendar year 1999.

Rationale: The expansion of the NHSDA to produce State level estimates required the establishment and availability of an expanded data collection system.

Data Source and Validity of Data: Program documentation on the NHSDA.

Target: FY 1999, Availability of expanded collection system.

Baseline: New initiative in 1998.

Progress Update: The target has been met. Data collection system is available.

Measure 2: Availability and timeliness of data in calendar year 2000.

Rationale: This will be measured in the number of months between close of the relevant time period for data collection and the availability of data in print and electronic form. The first data from the expanded NHSDA are being collected in calendar 1999. State and national estimates from 1999 survey will be available in calendar 2000.

Data Source and Validity of Data: Program documentation on the NHSDA.

Baseline: National data were available 8 months after close of data collection.

Target: FY 00: National and State data to be available 8 months after close of data collection. FY 01: Maintain at 8 months after close of data collection

Performance update: For FY 1999 National data was available 8 months after close of data collection. Target reached. In FY 2000, National and State data should be available 8 months after close of data collection. For FY 2001, National and State data should be available 8 months after close of data collection.

2.29 Program Title: Drug Abuse Warning Network (DAWN)

Performance Goals:	*Targets*	*Actual Performance*	*Refer-ence*
1: Availability and timeliness of data	FY 01: Maintain at less than 18 months after close of data collection FY 00: Less than 18 months after close of data collection FY 99: None. First included in FY 2000 plan.	FY 01: TBR FY 00: TBR FY 99: Achieved in 14 months FY 98: Baseline: 12 months	B127
Total Funding:	**1997: $2,771,000** **1998: $5,936,000** **1999: $5,176,000** **2000: $6,699,000** **2001Req: $7,000,000**		

2.29.1 Program Description, Context, and Summary of Performance

The goal of this program is to provide estimates of drug-related emergency department visits at the national level, and for 21 large metropolitan areas. This program obtains information on drug-related admissions to emergency departments and drug-related deaths identified by medical examiners. DAWN provides both a national estimate of emergency visits associated with substance abuse, and estimates for 21 large metropolitan areas.

In FY 1998, emergency department data from the 1996 survey were made available to the public 12 months after the close of the data collection period. In FY 1999, emergency department data from the 1997 survey were made available 18 months after the close of data collection. The delay in availability of 1997 data was due to a shift of data analysis responsibilities to a new contractor. The program is on course to improve timeliness in the availability of 1998 emergency department data.

2.29.2 Goal-by-Goal Presentation of Performance

Performance Goals: Performance goals for this activity relate to Goal 4: Invest in data for quality improvements and accountability. DAWN data are especially important to the Drug Enforcement Administration, which uses the data to detect new or emerging problems and to establish priorities for area surveillance.

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Measure 1: Availability and timeliness of data.

Rationale: This will be measured in the number of months between close of the relevant time period for data collection and the availability of data in print and electronic form. This measure will be taken annually, using FY 1998 as the baseline.

Data Source and Validity of Data: Program documentation.

Baseline: Emergency department data were available 12 months after close of data collection.

Target: FY 2000: Less than 18 months after close of data collection. FY 2001, maintain at less than 18 months after close of data collection

Progress Update: In FY 1999, emergency department data were available18 months after close of data collection. For FY 2000 emergency department data should be available less than 18 months after close of data collection. In FY 2001 maintain at less than 18 months after close of data collection.

2.30 Program Title: Drug Abuse Services Information System (DASIS)

Performance Goals	*Targets*	*Actual Performance*	*Refer-ence*
1: Availability and timeliness of data	FY 01: Maintain at less than 18 months after close of data collection FY 00: Less than 18 months after close of data collection FY 99: None. First included in FY 2000 plan.	FY 01: TBR FY 00: TBR FY 99: Achieved in 14 months FY 98 Baseline: 13 months	B127

Total Funding:	**1997: $5,515,000** **1998: $6,860,000** **1999: $7,586,000** **2000: $13,000,000** **2001 Req: $13,000.000**		

2.30.1 Program Description, Context, and Summary of Performance

The goal of this program is to provide information on the services available for substance abuse treatment in the United States, and on the characteristics of patients admitted to treatment. This program provides national and State level information on the substance abuse treatment system. DASIS contains information on the characteristics and services of all known treatment programs in the country, and information on patients admitted to treatment programs receiving public funds.

In FY 1998, data from the 1996 Uniform Facilities Data Set (UFDS), a component of DASIS, were made available to the public 13 months after the close of the data collection period. In FY 1999, data from the 1997 UFDS were made available 18 months after the close of data collection. The delay in availability of 1997 data was due to a shift of data collection responsibilities to a new contractor. The program is on course to improve timeliness in the availability of 1998 UFDS data.

2.30.2 Goal-by-Goal Presentation of Performance

Performance Goals: Performance goals for this activity relate to Goal 4: Invest in data for quality improvements and accountability. DASIS provides data necessary for the calculation of the treatment gap, a performance measure used by the Office of National Drug Control Policy to assess progress in the effort to reduce substance abuse. Information from DASIS is used to compile the National Directory of Drug Abuse and Alcoholism Treatment and prevention Programs, which is used extensively for treatment referrals. UFDS provides information for a sampling frame that is used by investigators conducting research on the quality of substance abuse treatment.

Measure: Availability and timeliness of data.

Rationale: This will be measured in the number of months between close of the relevant time period for data collection and the availability of data in print and electronic form. This measure will be taken annually, using FY 1998 as the baseline.

Data Source and Validity of Data: Program documentation.

Baseline: FY 1998 UFDS data were available 13 months after close of data collection.

Target: FY 1900 and FY 01, Maintain availability at less than 18 months after close of data collection

Progress Update: For FY 1999, UFDS data were available18 months after close of data collection. For FY 2000 UFDS data should be available less than 18 months after close of data collection. In FY 2001 maintain at less than 18 months after close of data collection.

APPENDIX TO THE PERFORMANCE PLAN

A.1 Approach to Performance Measurement: Methodology and Rationale

1. Key Definitions for SAMHSA GPRA Performance Plan

Measure: Typically a number or percent that reflects the count of program successes, for a defined period of time, defined in an operational manner by the program. Two types of measures are used:

--**Output Measure**: A number or percentage that reflects the productivity of a program, per unit of time; e.g., the number of grants awarded; the number of people for whom care was provided.

--**Outcome Measure**: A number or percent that reflects the effects of a program per unit of time, e.g., the number of customers who put new knowledge to use; the number of consumers who experienced beneficial effects as a result of care.

Rationale: The reason why the program chose the particular measure listed.

FY X Target: The minimal number or percent of successes expected to be achieved in specified fiscal year.

Baseline: The number or percent of successes observed in the specified reference year.

2. Measures Development Framework

Models

Two primary models for performance measures development have guided SAMHSA's performance measures development effort.

The "balanced scorecard" of Norton and Kaplan from Harvard captures many of the types of elements needed for the development of measures in the various areas that SAMHSA must address. Among other things, this approach to developing measures illustrates that different goals and perspectives lead to very different types of measures within the same operation -- some process, some outcome. This model also makes it easy to identify areas for future emphasis. For example, SAMHSA has invested considerable effort in the initial years of GPRA implementation in developing agency goals and program specific measures related to the "strategic results" perspective. SAMHSA has also done developmental work on customer satisfaction measures in multiple areas. A particular emphasis in this model is the use of customer satisfaction as an outcome measure. This concept has been incorporated within the SAMHSA GPRA measures where appropriate.

SAMHSA's Quality of Work Life initiation is an effort to address issues related to employee satisfaction, morale, skills and related issues. A next step would be to begin to incorporate effort and related success measures into aspects of the GPRA efforts that address management issues. The fourth perspective, internal process, also requires further scrutiny with the possibility of additional process measures being developed and incorporated into the plan if they are of sufficient impact.

S A M H S A

Balanced Scorecard
Perspectives, Goals, and Measures*

Perspective	**Goals**	**Measures**
Strategic Results	**Accomplish Mission**	**Return on Investment**
[		**Earned Value Added**

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Customer/Client	**Add Value for Customer**	**Customer Satisfaction**
[		**Customer Retention**
		New Customer Acquisition
		Market Share
Internal Process	**Use Resources Efficiently**	**Cycle Time**
[	**and Effectively**	**Quality/Defects**
		Cost
Learning/Growth	**Develop Work Force**	**Employee Satisfaction**
[		**Retention/Morale**
		Skills/System

* Norton & Kaplan, Harvard University

SAMHSA has developed a second, very simple model that has been helpful in visualizing and systematically approaching the task of performance measures development. That model represents a continuum from inputs and process measures through different types of output and outcome measures. Process measures describe the "how" of an activity; output and outcome measures describe the "why". Both are essential. This second model provides the foundation for an orderly way of addressing measures development that starts with inputs (e.g., program authorities; resources; goals); looks first at process and output measures (how well is this program administered? How can program outputs be increased or improved?) and then moves toward measures of outcomes.

S A M H S A

Framework for Performance Indicators

Model:

Input --> Process --> Output -->Proximal Outcomes --> Distal Outcomes

<-- HOW ? WHY ? -->

Example:

$ & Human Resources	**--> Training (Skills & Time)**	**-->Number of People Trained/Time**	**--> % with Skill X**	**-> % with Job Y**

3. Data Verification and Validation and Other Data Issues: See pages 17 and 18, as well as individual program narratives.

A.2 Changes and Improvements Over Previous Year

SAMHSA's current efforts are directed toward following through on the performance measurement commitments made in the FY 2000 plan, and obtaining needed data. For this submission, we are able for the first time to be able to report some block grant data for our CSAT and CMHS programs. More programs have baseline data, targets, and update data. Measurement development projects underway include further development of the goal level measures and core measures for evaluation, as well as strategies to aggregate our performance reporting. SAMHSA also plans to accomplish further work on the long term policy measures and indicators for our goal level measures.

A.3 Linkage to HHS and OPDIV Strategic Plans

Relationship to the HHS Strategic Plan

SAMHSA intends to revise its strategic plan by FY 2003. The HHS Strategic Plan is the HHS-wide GPRA strategic plan. SAMHSA's programs support all of the goals of the Department of Health and Human Services Strategic Plan. SAMHSA also is responsible for the FY 1999 Secretarial initiative, "Prevent Youth Substance Abuse," and contributes to all other Secretarial initiatives. Some of the ways in which SAMHSA contributes to the goals of the HHS Strategic Plan are as follows:

Reduce the Major Threats to the Health and Productivity of All Americans (Goal 1): SAMHSA's substance abuse prevention and treatment activities, both through the block grants and the KD&As, directly advance the achievement of "strategic objectives" under Goal 1 to curb alcohol abuse (1.4) and reduce the illicit use of drugs (1.5).

Improve the Economic and Social Well-Being of Individuals, Families, and Communities in the United States (Goal 2): SAMHSA programs, including the Children's Mental Health Program and the Starting Early/Starting Smart Program, (SESS) clearly contribute to the achievement of Goal 2.

Improve Access to Health Services and Ensure the Integrity of the Nation's Health Entitlement and Safety Net Programs (Goal 3): By supporting States in identifying and addressing substance abuse and mental health needs through the block grants -- and in reporting on their performance through a common set of performance measures, SAMHSA promotes not only the accomplishment of Goal 3, but also intergovernmental performance-based accountability.

Improve the Quality of Health Care and Human Services (Goal 4): SAMHSA's KD&A-funded models for substance abuse and mental health treatment improve the quality of a critical aspect of comprehensive and needed health care for Americans.

Improve Public Health Systems (Goal 5): SAMHSA's investments in improved national and state data systems, including performance data, and its support for workforce training directly improve public health systems in the United States.

Strengthen the Nation's Health Sciences Research Enterprise and Enhance its Productivity (Goal 6): SAMHSA's population-based and services research on substance abuse and mental health issues directly contribute to our Nation's health sciences research enterprise.

Relationship to OPDIV Strategic Plan

The HHS Strategic Plan fulfills GPRA strategic planning requirements for all OPDIVs. SAMHSA intends to release a new Strategic Plan by the end of 2003.

Relationship to National Drug Control Strategy and Healthy People 2010

SAMHSA has been fully involved in the Office of National Drug Control Policy's Performance Measures of Effectiveness (PME) effort. SAMHSA provides direct programmatic support to Goals 1 and 3 of the National Drug Control Strategy and the PME effort, and contributes to Goal 2. SAMHSA is represented on ONDCP's Steering Committee for each of these goals.

SAMHSA has participated in the development of the PME system for the Strategy, chairing or co-chairing each working group for every objective of Goal 1 and Goal 3, and participating in Goal 2 working groups. In addition to developmental and programmatic support, SAMHSA provides tracking data for many of the objectives of the Strategy. Refining measures, developing strategies, identifying data sources, and setting annual targets are now under discussion. Each SAMHSA GFA cites which Healthy People objective it contributes to.

For SAMHSA's six mission-level outcome measures and for the goals and objectives of the PME effort and Healthy People 2010, the intent is to establish, maintain, and if possible to accelerate a trend toward a desired target, not to set specific annual targets. Results in any one year are considered less significant than the cumulative result. In the context of the National Drug Control Strategy, the process of establishing targets under these circumstances is conceptualized as determining the "glide path." Moreover, since (1) these long-range goals represent a national effort, (2) SAMHSA is allocated only a portion of the dollars needed to address these problems, and (3) there are many factors influencing the outcomes other than SAMHSA's programs, the agency can influence only a portion of the national outcomes.

SAMHSA is the lead agency, with the National Institutes of Health, for the Substance Abuse chapter of the HHS Healthy People 2010, and for the Mental Health and Mental Disorders chapter. Healthy People 2010 will be released in January 2000.

A.4 Performance Measurement Linkages with Budget, Cost Accounting, Information Technology Planning, Capital Planning and Program Evaluation

Budget

Performance measurement is being conducted with virtually every significant SAMHSA program for which funding is requested. SAMHSA performance measures are designed to report the outcomes and progress achieved toward specific established goals. The high level of SAMHSA performance success evident in the data examined to date as well as the comprehensive performance measurement

systems incorporated will allow the Congress and the Executive Branch to assess SAMHSA's programs.

Human Resources

SAMHSA has made significant progress in workforce planning. A group consisting of program managers, budget analysts, administrative experts and a union representative are meeting regularly on this project. Having gathered background on the process and the practices in other organizations which are in the midst of or have completed a workforce plan, the group is preparing a statement of work for development of SAMHSA's workforce plan. An initial plan should be in place by July of FY 2000.

SAMHSA's Quality of Worklife (QWL) Steering Committee, chaired by the Deputy Administrator, is reviewing a full range of initiatives, including those requested by the Secretary as well as SAMHSA specific endeavors. The members represent senior staff as well as non-managerial staff, including a representative from the Union. The Committee's current major activity is part of the effort to effectively manage change. This involves SAMHSA's use of Appreciative Inquiry to consider what would be the vision of a quality work life for the Agency. Following the Committee's acceptance of provocative propositions created by three employee focus groups, the process has been presented to senior management and is now being utilized in sessions with managers, supervisors and team leaders to test its acceptance as a method of positive change in the Agency. Additional initiatives overseen by the QWL Steering Committee are the telecommuting pilot, the workplace learning program, which is on the verge of implementing a managerial training program and continues to provide team training by inside trainers, and the continuation of Partnership Awards, where awards are given from the staff of one major office or center to staff in another component. Other ongoing efforts include enriching communications between managers and employees; strengthening family friendly programs; managing diversity with specific efforts; installing a health promotion program; continuing to

support the food recovery program; and, improving safety and encouraging adoption of better workplace ergonomics.

Cost Accounting

SAMHSA maintains careful fiscal controls over the planning, expenditure and monitoring the use of resources and recognizes the benefits of cost accounting for management decision making . In the past year, six specific areas were audited to ensure proper accountability. SAMHSA has fully implemented the Chief Financial Officer Act of 1990 by establishing the position of CFO, submitting a five year financial management plan with annual status reports and preparing the required annual financial statements. In addition SAMHSA is on schedule to complete its annual audited financial statement in order to fully implement the Government Reform Act of 1994 (GMRA).

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The financial statements, supporting books and records for SAMHSA are prepared by the Division of Financial Operations Program Support Center (PSC). A CORE accounting system utilizes general ledger accounts and provides on-line query capability for accounting. The PSC's accounting systems are in accordance with the generally accepted auditing standards contained in the Government Auditing Standards issued by the Comptroller General of the United States and Office of Management and Budget Bulletin 93-06, "Audit Requirement for Federal Statements."

Information Technology

Improvements in Information technology systems support improved performance . For example, during FY 1999, SAMHSA implemented a number of enhancements to achieve Y2K compliance, reduce costs, increase productivity, decrease processing time, improve service quality, and increase customer satisfaction. These enhancements included progress in the areas listed below.

SAMHSA's migration to the Windows 95 32 bit operating system is complete. An analysis of migrating to Windows 98/Windows NT/Windows 2000 is currently underway. Overall system speed improved making the move from 16-Bit to 32-Bit operating system. This also allowed for true multi-tasking, that directly supports increased capabilities for improved staff productivity. Upgrading the operating system to 32-bit also allowed the systems to take full advantage of the increased processing power and memory that are loaded on the newest systems. In addition, it allowed us to upgrade the applications in-step and provide more efficient and powerful desktop systems in support of staff productivity.

The conversion to a Windows dial-in capability is complete. Since more of our programs are now accessible to the users, and more users are taking advantage of this service, we are confident in improvements in productivity. For example**,** as a result of this upgraded approximately (5) to (10) times are many staff use this system in an average month.

The migration to a newer version of GroupWise, including Internet access to the e-mail system, is complete. Future enhancements and upgrades are now being evaluated. Some of these enhancements would be: automatic spell checking of outgoing messages; and standardizing fonts and appearances of incoming and outgoing messages. These enhancements will be discussed with the SAMHSA Computer users Group before they are implemented. If acceptable, the enhancements are expected to be implemented within the next 2-3 months.

Since this newer version has a web interface, and we have a new remote access system installed, users are now able to easily check mail from anywhere in the world.

A network FAX utility that would allow SAMHSA users to send faxes directly from any Windows application (WordPerfect, Lotus, etc) is under review for implementation. It is estimated that this capability will be available by May. This technology would greatly reduce the costs associated with

outbound faxing in SAMHSA. In addition, we won't have to allocate any additional funds to Contractors who perform mass faxing for the Agency. As a result of having one centralized fax server, instead of many individual fax machines performing redundant services, this will improve productivity.

Development of an Intranet capability providing an "internal Internet" for SAMHSA staff is under review. Users could access the Intranet through Netscape and have immediate access information. The first phase of the Intranet includes a centralized staff directory developed as part of the AIMS system.. The second phase of the SAMHSA Intranet project is beginning with interviews of Office and Center staff to solicit ideas and requirements for a more comprehensive use of the Intranet technology. With one centralized staff directory, the cost of maintaining multiple staff directories would be eliminated. Increased productivity could be achieved by entering data is entered into a single source, thus reducing duplication of effort and the possibility of introducing new errors. In addition, the creation of Lotus Notes, would allow automated transfers of data files to other government components without manual intervention thus providing up-to-date and consistent SAMHSA information to other components.

SAMHSA's Division of Information Resources Management (DIRM) is continuing to work on a project to automate SAMHSA's administrative functions and integrate electronic forms with electronic signatures. This will provide consistent control of data and eliminate duplication of transaction and information entry, while standardizing procedures for processing administrative documents and related transactions in SAMHSA's current operating environment. It will in short, produce a comprehensive, enterprise-wide administrative system increasing efficiency and lowering costs. AIMS will provide SAMHSA administrative staffs with a centralized database and tracking system of "core" data. The system will allow for easy tracking of documents through the approval process as well as allow for management reports. Evaluations of all training will be kept and training satisfaction can be assessed.

The modification to all of SAMHSA's internal systems was completed and all of SAMHSA's systems were certified as Y2K compliant. Independent verification and validation of SAMHSA's

mission critical systems was completed. There will be no down-time due to Year 2000 considerations.

All of SAMHSA's applications software is currently being migrated to Windows versions. This migration will result in improved data structures and systems that fully integrate with other Windows-compliant software and systems. The new Windows based Client/Server applications, with their inherent RDBMS (Relational Database Management System) provide for: the opportunity to integrate information across applications; improved data integrity; tighter security; faster response time for queries; the potential for improved reporting capabilities; and the ability to integrate with existing third party software and tools. While all current DOS-based SAMHSA-wide systems are slated for migration, the emphasis is currently on the development of Client/Server Windows-based The user will have enhanced features available and the systems.

An upgrade of the current Netscape software is being planned which will improve the ease of use of the Internet browser and will enhance the security of WEB access. Most of the current functions and

capabilities will remain under the new version and it will also allow for tighter security and access to more secure web sites. The encryption technology on this version will be 128-bit, and this is important since many of the newer Intranet sites that are being advertised within DHHS require the use of this more current and more secure version of the browser. Implementation of this new Netscape version is planned for May. This upgrade of Navigator provided a higher level of encryption capabilities and a newer version of the core application. These two features allowed SAMHSA employees to use the browser to do more things than before and provided a more secure environment on the Internet.

SAMHSA's information resources management (IRM) mission is to support program mission accomplishment by ensuring that efficient and effective technology resources are available to all SAMHSA components; resources are properly used to support the technology needs of the programs; and SAMHSA's external customers are well served by the funds expended for these systems and services, leading to more effective prevention and treatment service delivery programs nationwide.

SAMHSA has established an information technology architecture (ITA) which ensures inter-operability among systems and reduces redundancy. This reduces acquisition and training costs, increases productivity, improves service quality, and increases customer satisfaction. All of SAMHSA's computers are connected to the Agency LAN. Network services, e.g., e-mail, calendaring, enterprise-wide database applications, and Internet connectivity increase information sharing and reduce costs for information retrieval. The entire Agency uses ISDN telecommunications. In conjunction with the PHS 5ESS digital switch, SAMHSA benefits from the digital voice, data, and video capabilities and cost savings of ISDN technology.

Capital Planning

In implementing the GPRA and the Ginger-Cohen Act of 1996, SAMHSA considers how to make decisions in a business like context to ensure an acceptable return on investment (ROI) and to direct linkage of the department's mission and strategic objectives. For example, in the previous section on Information Technology SAMHSA's migration to the Windows 95 32 bit operating system and conversion to a Windows dial-in capability involved direct consideration of acquisition costs versus gains to be realized in productivity. SAMHSA is now in the process of developing formalized models of capital planning for implementation in Information Technology and other possible areas of operation.

Program Evaluation

SAMHSA continuously conducts program evaluation to ensure that resource utilization is optimized through program effectiveness and efficiency. Specifically, SAMHSA's chief evaluation priorities are to: (1) improve performance measurement and (2) evaluate program effectiveness. Evaluation directly

supports policy development and program management. Evaluation is conducted internally by SAMHSA staff, by contractors and as requested by the DHHS Office of the Inspector General and the General Accounting Office. The sections below contain reporting on SAMHSA evaluation activities for FY 99.

In July 1999, SAMHSA completed the "National Evaluation Data and Technical Assistance Center" (NEDTAC) evaluation. The Center provides a variety of evaluation technical assistance and training services to CSAT grantees and staff plus centralized management and analysis services in support of the evaluation of several large demonstrations targeted to special populations including criminal justice, women, rural, and culturally distinct and adolescent populations. NEDTAC represents part of an overall evaluation strategy that builds upon prior findings and seeks to identify a set of consistent evaluation questions that can be applied across similar substance abuse programs targeted to special populations. It seeks to identify data elements to provide uniform information across sites so that comparisons of effectiveness can be made. A variety of reports encompassing program results as well as technical and methodological topics will be produced.

In addition to completing this evaluation in FY 99, 8 evaluation projects continue in operation through the reporting period. These projects were:

1) "Evaluation of the HHS Access to Community Care and Effective Services and Supports"

2) "Evaluation of the High Risk Youth Substance Abuse Prevention Initiatives Funded in 1994 and 1995"

3) "Cross-site Evaluation of the Community Prevention Coalitions Demonstration Grant Program"

4) "State Substance Abuse Managed Care Evaluation Program"

5) "Persistent Effects of Treatment Studies"

6) "Treatment Improvement Protocols Field Evaluation"

7) "Evaluation of Opioid Treatment Program Accreditation Project"

Appendix B.1

TOPPS II CORE DATA SET

Time One (Admission) and Time Three (Follow-up)
and
Time Two (Discharge)

Key Data Set Variables

1. Age
2 .Gender
3. Ethnic Group
4. Race
5. Education
6. History in a controlled environment
7. Frequency of psychiatric/medical/emergency room hospital admissions in the last 6 months
8. Use of self-help groups
9. Pregnant
10. Number of Children
11. Number of children in the home
12. Child protective status of any children
13. Employment status
14. Enrollment in a school or training program
15. Criminal/Arrest record
16. Living arrangements
17. Primary/ Secondary/Tertiary Drug Problem
18. Specific type of substance abuse
20. Frequency of use
21. Age at first use
22. Methods of administering drugs
23. Date of last contact
24. Reason for discharge, transfer or discontinuance of treatment

For a complete copy of the study instrument, contact the Center for Substance Abuse Treatment

Appendix B.2

Mental Health Services Indicators

Criterion 1: Comprehensive Community Based Mental Health System.

ACCESS INDICATORS

- Percentage of SMI persons (or SED persons or their parents) receiving services who rate access to care positively;
- Number of persons with SMI (or SED) who are receiving case management services;
- Number of persons with SMI (or SED) who are receiving housing services;
- Number of persons with SMI who are receiving employment services;
- Number of admissions to state and county hospitals among persons with SMI (or SED);
- Number of patients-in-residence in state and county hospitals among persons with SMI (or SED);

APPROPRIATENESS/QUALITY INDICATORS

- Percentage of SMI population (or SED persons or their parents) receiving services who rate the quality and appropriateness of care positively;
- Increase percentage of SMI population (or SED persons or their parents) receiving services who positively rate respect and caring by their providers;
- Increase percentage of SMI population who are actively involved in decisions regarding their own treatment;
- Percentage of parents of children and adolescents who are in the SED population who are actively involved in decisions regarding their child's treatment;
- Percentage of persons discharged from psychiatric inpatient care who receive a follow-up, face-to-face visit within seven days of discharge;
- Percentage of persons discharged from psychiatric emergency care who receive a follow-up, face-to-face visit within seven days of discharge;
- Percentage of SMI population who are receiving "supported housing" services;
- Percentage of SMI population who are receiving "supported employment" services;
- Percentage of SMI population who are receiving "assertive community team" services;
- Percentage of SMI population who receive a physical health examination annually;

OUTCOME INDICATORS

- Percentage of SMI population (or SED persons or their parents) receiving services who report positive outcomes of care (or for whom positive changes are reported);
- Percentage of SMI population for whom there are positive changes in employment;
- Percentage of SED population for whom there is improvement in school functioning;
- Percentage of SMI population for whom there are positive changes in living situation;
- Percentage of SMI population for whom there are improvements in personhood, hope, and recovery;
- Percentage of SMI/SED population for whom there are positive changes in level of functioning;
- Percentage of SMI/SED population for whom there is reduced distress from the symptoms of mental illness;
- Percentage of SMI/SED population for whom there is either no impairment or reduced impairment from substance abuse;
- Percentage of persons served with SMI who experience adverse outcomes of mental health services;
- Percentage of persons readmitted to psychiatric inpatient care within 30 days of discharge.
- Percentage of SMI population who spend one or more days in a jail or prison.

Criterion 2: Estimates of Prevalence and Treated Prevalence and Mental Health Systems Data.

POPULATION ACCESS INDICATORS

- Percentage of adults with serious mental illness who receive publicly funded services;
- Percentage of children with serious emotional disturbance who receive publicly funded services.

SPECIAL POPULATION INDICATORS

For all illustrative indicators shown under Criterion 1 and 2 above or others that states may develop, estimation of performance on the same indicators for significant sub-populations, including breakouts by

- Gender
- Ethnicity
- Race
- Sub-state geographic areas
- For Adults, age sub-groupings
- For Children & Adolescents, age sub-grouping

Criterion 3: Targeted Services to Homeless and Rural Populations.

- Percentage of homeless persons with SMI (or SED) and who receive mental health services.
- Percentage of rural persons with SMI (or SED) and who receive mental health services.
- For all, relevant, illustrative indicators shown under Criterion 1 and 2 above or others that states may develop, estimation of performance on the same indicators for persons with SMI/SED and homeless and for persons who are SMI/SED and living in rural areas of the state.

Criterion 4: Management Systems.

- Proportion of state mental health block grant funds allocated to innovative programs;
- Percentage of SMHA-controlled expenditures for community programs of total SMHA-controlled expenditures;
- Mental health expenditures *per capita*;
- Mental health expenditures *per person served;*
- Extent of involvement of consumers and families in (a) policy development, (b) planning, and (c) quality assurance/monitoring at the statewide level, the local mental health authority level, and the provider level.

MENTAL HEALTH, MEDICAID MANAGED CARE PLANS INDICATORS

- Number of persons with SMI (or SED) and who are enrolled in Medicaid managed care for health and mental health services (integrated plan) or mental health/behavioral health services only (carve out plan);
- Per member per month plan premium rate (statewide average);
- Percent of total plan expenditures attributable to (1) Medical loss, (2) Administrative loss, and (3) Net Profit/loss.
- Extent of involvement of consumers and families in (a) policy development, (b) planning, and (c) quality assurance/monitoring within the managed care plan.

Criterion 5: Integration of Children's Services.

- Percentage of children with SED who are placed out-of-home (e.g., foster care, residential home, juvenile detention).
- Percentage of children with SED who are attending school regularly;
- Percentage of children with SED who are also receiving special education services;
- Percentage of children with SED who are also clients of the juvenile justice system;
  Percentage of children who are SED who are also receiving substance abuse services

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Appendix B.3

Core Client Outcomes for Discretionary Programs

Mental Health and Substance Abuse Treatment:

Children: Over the past year, percent of children/adolescents under age 17 receiving services increased who:

Key Indicators	Rationale

-had no past month use of alcohol or illegal drugs (population data limited to 12-17 year olds)	*Source*: Addiction Severity Index *Supports*: ONDCP Performance Measure - Goals 1 and 3; Healthy People 2010 - Chapter 26 *Rationale*: This indicator is a fundamental, generally accepted measure of the prevalence of substance abuse. National trend data that can serve as a benchmark are available over many years.
-were residing in a stable living environment	*Source*: Modified McKinney Demonstration Projects *Rationale*: The stability of a child's living environment provides an indicator of treatment success. In SAMHSA's work with States, this indicator was chosen both by mental health and substance abuse State directors as a core indicator of system success.
-were attending school -had no/reduced involvement in the juvenile justice system	*Source*: Modified Addiction Severity Index *Supports*: ONDCP Performance Measure - Goal 3 *Rationale*: Attending school and lack of involvement with the juvenile justice system also are commonly accepted indicators of treatment success both for mental illness and for substance abuse; these indicators were chosen by mental health and substance abuse directors as core indicators of system success.

Adults: Over the past year, percent of adults receiving services increased who:

Key Indicators	**Rationale**
-experienced no/reduced alcohol or illegal drug related health, behavior, or social consequences, including the misuse of prescription drugs	*Source*: McKinney Demonstration Projects *Supports*: ONDCP Performance Measure - Goal 3 *Rationale*: National standards; chosen by State Directors as core indicators.
-had a permanent place to live in the community	*Source*: Modified McKinney Demonstration Projects *Rationale*: Commonly accepted indicator of success; chosen by State Directors as core indicators.
-were currently employed or engaged in productive activities -had no/reduced involvement with the criminal justice system	*Source*: Modified Addiction Severity Index *Supports*: ONDCP Performance Measure - Goal 3 Healthy People 2010 - Chapter 18 *Rationale*: Commonly accepted measures of success; chosen by State Directors as core indicators

Substance Abuse Prevention:

Children: Over the past month, the percent of children:

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Key Indicators	**Rationale**
-Using substances declined for those receiving services compared to the national average or project baselines	*Source*: Modified Addiction Severity Index *Supports*: ONDCP Performance Measure - Goal 1 *Rationale*: Core indicator for prevention; national average available.
-Having used substances showed an increase of age of first use	*Source*: National Household Survey *Supports*: ONDCP Performance Measure - Goal 1 Healthy People 2010 - Chapter 26 *Rationale*: Core indicator for prevention; national data available.
-Student Survey of Risk and Protective Factors for increases of those receiving services compared to the national average or project baselines -MTF -Tanglewood Research	*Source*: National Household Survey *Supports*: ONDCP Performance Measure - Goal 1 Healthy People 2010 - Chapter 26 *Rationale*: These indicators of attitudes/beliefs are important correlates of substance abuse that help explain trends in substance abuse. Core indicators for prevention; national data available.

Adults: Over the past month, the percent of parents/adults:

Key Indicators	**Rationale**
-Using illegal drugs declined for those receiving services compared to the national average or project baselines.	*Source*: Modified Addiction Severity Index *Supports*: ONDCP Performance Measure - Goal 1 *Rationale*: Core indicator for prevention; national data available.

-Having used substances showed an increase in age of first use	*Source*: National Household Survey *Supports:* ONDCP Performance Measure - Goal 1; Healthy People 2010 - Chapter 26 *Rationale*: Core indicator for prevention; national data available.
-Strongly disapproving of substance use increased for those receiving services compared to the national average or project baselines. -Perceiving personal/health risks associated with the consequences of substance abuse/misuse increased for those receiving services compared to the national average or project baselines.	*Source*: National Household Survey *Supports*: ONDCP Performance Measure - Goal 1 Healthy People 2010 - Chapter 26 *Rationale*: These indicators of attitudes/beliefs are important correlates of substance use that help explain the patterns and trends in substance use.

Additional Measures for Substance Abuse Treatment and Prevention

Key Indicators	**Rationale**
-Over the past month, the percent of adults receiving services increased who had no past month use of illegal drugs or misuse of prescription drugs	*Source*: Modified Addiction Severity Index *Supports*: ONDCP Performance Measure - Goal 3 *Rationale*: Demonstrates effectiveness of prevention or treatment services.
-Over the past month, the percent of youth (population data limited to 12-17 year olds) receiving services increased who experienced no substance abuse related health, behavior, or social consequences	*Source*: Modified Addiction Severity Index *Supports*: ONDCP Performance Measure - Goal 3 *Rationale*: Demonstrates effectiveness of prevention or treatment services.

B. 4 Appendix for Center for Substance Abuse Prevention Supplemental Materials

CSAP Overview

2.8.2 SAPT Block Grant

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Measure One

Sample state key findings:

North Carolina Student Survey

1) For students in grades 10 to 12, those who approved of someone their age using substances were two to three times more likely to have used substances themselves.
2) In both the middle school and high school surveys, antisocial behaviors and youths' perceptions of the ease of obtaining substances were strongly related to substance use.
3) Between grades 6 and 9, the rate of substance use steadily increased.

Texas - Household Survey/ Border Households in Texas & Mexico

1) Border residents were less likely to have used illicit drugs within the past year than Texas residents living elsewhere in the State. They were also less likely to report having any alcohol- or drug-related problems. This finding was true for Hispanics and non-Hispanics alike.
2) Rates of lifetime and past-year illicit drug use were three to five times higher in the US border cities as compared with their Mexican counterparts.

Louisiana Homeless Survey

1)The reasons youth mentioned most frequently for being away from home included an argument with someone they lived with (57%) or because they were either homeless or ran away from home (56%).
2) Youth who felt they would not be caught by the police for using alcohol or marijuana reported higher rates of past month alcohol use.

Iowa Social Indicators Study

1) Identification of the top 5 risk indicators by county within each region.
2) Inventory of public data indicators of substance abuse risk.

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